

TO HOSPITAL: A. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
04651													
1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN 1b 1 hr 10 min d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SUBURBAN HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 25 SILVER SPRING d. STREET ADDRESS 8403 DIXON AVE APT 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) LAST ALEX MIDDLE PETER FIRST ANGELO						4. DATE OF DEATH Month 4 Day 8 Year 1962							
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/18/81		9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 8 Days 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager-Retired				10b. KIND OF BUSINESS OR INDUSTRY Theatre Business				11. BIRTHPLACE (County & State, or foreign country) Kamari, Greece		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Peter Alex						14. MOTHER'S MAIDEN NAME Mary TRIANTIFFILOU							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give year or dates of service) NONE						16. SOCIAL SECURITY NO. 280-01-8980						17. INFORMANT Name Helen A. Saridakis Address 10702 Woodsdale Dr. Silver Spring	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GASTRO-INTESTINAL HEMORRHAGE 155.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC CANCER (c) HEPATOMA PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -												INTERVAL BETWEEN ONSET AND DEATH < 24 HRS > 9 MONTHS AT LEAST 9 MONTHS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from DEC 19, 1961 , to APRIL 8, 1962 , that (I) (we) last saw the deceased alive on APRIL 8, 1962 , and that death occurred at 5⁰⁰ P , from the causes and on the date stated above.													
22a. SIGNATURE James A. Roberts M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED APRIL 8, 1962					
22c. PHYSICIAN'S NAME (Type) JAMES A. ROBERTS M.D.						22d. ADDRESS 8907 GEO. AVE. SILVER SPRING, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 4-11-62		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery			23d. LOCATION (City, town or county) (State) Rockville Montgomery Co, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Fisher Warner E. Pumphrey, Inc. Silver Spring, Maryland						25a. REC'D BY REGISTRAR APR 12 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be signed by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04653

04652

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. LENGTH OF STAY IN 1b 56 Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) KENSINGTON GARDENS SANITARIUM		d. STREET ADDRESS 4903 Flint Drive	
3. NAME OF DECEASED (Type or print) First ALICE Middle Elvie Last ALLEN		4. DATE OF DEATH Month APRIL Day 11 Year 1962	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 MAY 1878
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 83 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Business Secretary		10b. KIND OF BUSINESS OR INDUSTRY Secretary	
11. BIRTHPLACE (County & State, or foreign country) Shanghai, China		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Young John ALLEN		14. MOTHER'S MAIDEN NAME Mary Houston	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Allen R. Turner-Nephew-same 2d		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Long (Anterolateral) Heart Disease 420.0 DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Serious - age 83 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 11 AM yr yr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/9/62 19..... to 4/11/62 19....., that (I) (we) last saw the deceased alive on 4/9/62 19....., and that death occurred at 11 AM from the causes and on the date stated above.			
22a. SIGNATURE Sam Allen MD M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Sam Allen MD		22d. ADDRESS 10407 Samson St. Kensington MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 4/11/62	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR APR 13 62 25b. REGISTRAR'S SIGNATURE Arthur S. Prince	

014739

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04654

04653

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 17 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Arlington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 83x3 d. STREET ADDRESS 1625 S. Stafford Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frank Middle Ervin Last Altizer		4. DATE OF DEATH Month April Day 30 Year 1962	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-9-22
9. AGE (In years last birthday) 40 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter	11. BIRTHPLACE (County & State, or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Harvey Altizer	
14. MOTHER'S MAIDEN NAME Lavinie I. Altizer		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 1942-1944	
16. SOCIAL SECURITY NO. 1942-1944		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 393.2 DUE TO Staph infection Conditions, if any, which gave rise to immediate cause (b) Mastoiditis (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 e.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that X (this hospital) attended the deceased from April 13, 1962 to April 30, 1962 , that (X) we last saw the deceased alive on April 30, 1962 , and that death occurred at 1055 AM from the causes and on the date stated above.			
22a. SIGNATURE Robert K. Middlekoff M.D.		22b. DATE SIGNED April 30, 1962	
22c. PHYSICIAN'S NAME (Type) ROBERT K. MIDDLEKOFF LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-3-62	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City, town or county) (State) Arlington, Virginia
24. FUNERAL DIRECTOR'S SIGNATURE Murphy Funeral Home		25a. REC'D BY REGISTRAR MAY 3 '62	25b. REGISTRAR'S SIGNATURE Arthur L. Kraus

(M)

100-1000

04028

Virginia

Washington

Washington

Washington (Rural)

17 Oct

100-1000

U. S. Naval Hospital

April 30

April 30

April 30

April 30

100

100-1000

100

Washington

100-1000

100

Virginia

Washington

Washington, D. C.

John Henry Hospital

Washington, D. C.

100-1000

100

Handwritten notes:
100-1000
100-1000
100-1000

100

April 30, 1962
April 30, 1962
April 30, 1962

April 30, 1962
April 30, 1962
April 30, 1962

April 30, 1962
April 30, 1962
April 30, 1962

Handwritten signature:
Robert E. M. [illegible]

U. S. Naval Hospital, Washington, D. C.

Washington, D. C.

Washington, D. C.

April 30, 1962

April 30, 1962

Washington, D. C.

Washington, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) #7 South Adams Street		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS #7 South Adams Street a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clarence Edward Anders		4. DATE OF DEATH April 8 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 12, 1890 71 yrs. 3 16
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Post Office-ret		10b. KIND OF BUSINESS OR INDUSTRY Mail	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles E Anders		14. MOTHER'S MAIDEN NAME Sarah Hahn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) WW Yes WW 1 None		16. SOCIAL SECURITY NO. Edna M. Anders-Wife-same 2d	
17. INFORMANT Edna M. Anders-Wife-same 2d		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO ARTERIAL HYPERTENSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO GENERALIZED ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CHRONIC RENAL FAILURE		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 20 YEARS 20 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (This hospital) attended the deceased from JAN. 1, 1956 to APRIL 8, 1962 that (I) (we) last saw the deceased alive on APRIL 5, 1962 and that death occurred 6:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Gordon S. Rosenberger M.D.		22b. DATE SIGNED APRIL 8, 1962	
22c. PHYSICIAN'S NAME (Type) Gordon S. Rosenberger		22d. ADDRESS 310 West Montgomery Ave. Rockville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/11/62	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town or county) (State) Rockville, Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR APR 13 '62 25b. REGISTRAR'S SIGNATURE Charles L. Hanna	

01551

01552

Montgomery

Montgomery

Montgomery

Rockville

Rockville

77 South Adams Street

77 South Adams Street

03

8

April

Distance toward Rogers

2.10

Dec. 12, 1960

White

Male

USA

Married

Mail

Post Office

Rock Hill

Charles F. Rogers

John W. Rogers - 30

Home

Box 1

2 days

Estimated

Estimated

2.10

Estimated

Estimated

2.10

Estimated

Estimated

Y

Estimated

Estimated

Jan 1 1961

Jan 1 1961

Robert A. Rogers

Rockville

Rockville

4/1/62

Rockville

Rockville

Rockville

4/1/62

Rockville

04656

04655

1. PLACE OF BIRTH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN b 18 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RESMOR HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 3130 Wisconsin Ave. NW e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last MATHILDA ANDERSON				4. DATE OF DEATH Month Day Year April 27 1962											
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 19, 1876		9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Denmark				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jensen				14. MOTHER'S MAIDEN NAME Jensen											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO.				17. INFORMANT Address Elna Anderson (daughter) Same as above							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis with Infarction 420.0 DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Metastatic Carcinoma Liver												INTERVAL BETWEEN ONSET AND DEATH 48 hours			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21. I certify that (I) (the hospital) attended the deceased from June 1957 to April 27, 1962 that (I) (we) last saw the deceased alive on 4-27-1962 and that death occurred at 7:30 P.M. from the causes and on the date stated above.															
22a. SIGNATURE P.P. Andrews				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 4-27-62							
22c. PHYSICIAN'S NAME (Type) P.P. ANDREWS				22d. ADDRESS 4201 Resenden St NW Wash D.C.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/30/62		23c. NAME OF CEMETERY OR CREMATORY Greenwood Cem.				23d. LOCATION (City, town or county) (State) Eustis Fla							
24. FUNERAL DIRECTOR'S SIGNATURE Chas. Rose Funeral Home				ADDRESS 5103 Wisconsin Ave NW Washington D.C.				25a. REC'D BY REGISTRAR DATE APR 30 '62		25b. REGISTRAR'S SIGNATURE Carlton L. House					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0155

CERTIFICATE OF DEATH

1881

M

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04657											
Items 23 Film 0312 5/3/62 ink											
CERTIFICATE OF DEATH											
04656 128-868											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Wash. D.C.</u> b. COUNTY <u>✓</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Inkoma Park</u>				c. LENGTH OF STAY IN 1b <u>23 1/2 NR.</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitation & Hospital</u>				d. STREET ADDRESS <u>515 Kennedy St N.W.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Google</u> Middle <u>John</u> Last <u>Annmatenas</u>				4. DATE OF DEATH Month <u>Apr</u> Day <u>1</u> Year <u>1962</u>							
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>10-16-34</u>		9. AGE (In years last birthday) <u>27</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver Bakery</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Annmatenas</u>				14. MOTHER'S MAIDEN NAME <u>—</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>Chart Washington San & Hosp.</u>				17. INFORMANT <u>Chart Washington San & Hosp.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral hemorrhage, left</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>5 April 1962</u> to <u>6 April 1962</u> that (we) last saw the deceased alive on <u>6 April 1962</u> and that death occurred at <u>2:59 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>R. A. Mendelsohn</u>				M.D. <u>✓</u>				ATTENDING PHYS. <u>✓</u> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Robert A. Mendelsohn</u>				22d. ADDRESS <u>1015 Spring St., Silver Spring, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/10/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cem.</u>				23d. LOCATION (City, town or county) (State) <u>Bladensburg, Md.</u>			
24. FUNERAL HOME SIGNATURE <u>Rinaldi Funeral Home</u>				ADDRESS <u>7400 Balto Ave. N.W.</u>				25a. REC'D BY REGISTRAR <u>APR 30 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Travis</u>	

M

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04658

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04657

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>40 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2317 Michigan Ave</u>				d. STREET ADDRESS <u>2317 Mich. Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Askins</u> Last <u>Askins</u>				4. DATE OF DEATH Month <u>Apr</u> Day <u>11</u> Year <u>1962</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-15-1884</u>	
9. AGE (In years, months, days) <u>77</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labour</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>Elliott Askins</u>			
14. MOTHER'S MAIDEN NAME <u>Agnes</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>1309</u>				17. INFORMANT <u>Agnes A. Russell</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> 422.1 DUE TO (b) <u>Chronic myocarditis</u> DUE TO (c) <u>Arterio-sclerotic vascular disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr</u> <u>month</u> <u>yr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>o.m.</u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>4-11-62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4/14/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial.</u>	
				22d. LOCATION (City, town, or country) <u>Sandy Spring, Md.</u>		(State)	
23. FUNERAL DIRECTOR <u>Robert L. Suorden</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 23 '62</u>	
				24b. REGISTRAR'S SIGNATURE <u>Robert L. Suorden</u>			

MEDICAL CERTIFICATION

1952

(M)

Blank document with faint horizontal lines and a circular stamp on the right side.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04659		04658	
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN b. <u>3 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SUBURBAN Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>ORANGE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCK TAVERN</u> d. STREET ADDRESS <u>DRURY LANE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SILAS</u> Middle <u>B</u> Last <u>AXTELL</u>		4. DATE OF DEATH Month <u>4</u> Day <u>29</u> Year <u>1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/30/85</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Law</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Perry, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lucian V. AXTELL</u>		14. MOTHER'S MAIDEN NAME <u>Josephine</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war and dates of service)		16. SOCIAL SECURITY NO. <u>Informant</u>	
17. INFORMANT <u>wife - Elizabeth M. AXTELL</u>		Address <u>420.0</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> (a), stating the underlying cause last. DUE TO (c) <u>4 hours</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Embolization</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> a.m. <u>0</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>APRIL 28, 1962</u> to <u>APRIL 29, 1962</u> that (I) (we) last saw the deceased alive on <u>APRIL 29, 1962</u> and that death occurred at <u>1:25 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert G. Angle</u>		22b. DATE SIGNED <u>4/29/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT G. ANGLE</u>		22d. ADDRESS <u>Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>5/2/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAY 4 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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Bethesda, Maryland

Robert A. Pumphrey, Bethesda, Maryland
Cremation 5/2/02 Cedar Hill Crematory, Solisland, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The funeral director, or the funeral director, may be required to sign the death certificate. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04659

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>FAIRFAX</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRFAX</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRFAX</u> 83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAIRFAX NURSING HOME</u>		d. STREET ADDRESS <u>925 E. Lee Hwy</u>	
3. NAME OF DECEASED (Type or print) First <u>DANTE</u> Middle <u>AZARIO</u> Last <u>AZARIO</u>		4. DATE OF DEATH Month <u>4</u> Day <u>14</u> Year <u>1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 6 1890</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u> Hours <u>14</u> Min. <u>1962</u>	IF UNDER 24 HRS. Months <u>7</u> Days <u>14</u> Hours <u>14</u> Min. <u>1962</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Motel</u>	11. BIRTHPLACE (State or foreign country) <u>Italy</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Jack Azario</u>	
14. MOTHER'S MAIDEN NAME <u>Ernestine Plane</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>146-16-7950</u>		17. INFORMANT Address <u>Mrs. Dante Azario</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>October 18, 1960</u> to <u>April 11, 1962</u> that (I) (we) last saw the deceased alive on <u>April 13, 1962</u> and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Boris Rabkin</u> M.D.		22b. DATE SIGNED <u>4/14/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>BORIS RABKIN, M.D.</u>		22d. ADDRESS <u>1019 University Blvd East Silver Spring, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/17/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Fairfax, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles M. West</u> ADDRESS <u>Fairfax, Virginia</u>		25a. REC'D BY REGISTRAR <u>APR 17 1962</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>			

CERTIFICATE OF DEATH

10-20-70

WILLIAM M. WILSON

Male White

Age 74

Married

Occupation: Retired

Place of Birth: New York, N.Y.

Place of Death: New York, N.Y.

Cause of Death: Heart Disease

Immediate Cause: Myocardial Infarction

Underlying Cause: Atherosclerosis

Contributing Cause: Hypertension

Period of Illness: 2 weeks

Place of Death: Home

Attending Physician: Dr. J. H. Smith

Signature of Physician: [Signature]

Date of Death: 10-20-70

Time of Death: 11:00 AM

Place of Death: Home

Signature of Informant: [Signature]

Date of Report: 10-25-70

Signature of Informant: [Signature]

Date of Report: 10-25-70

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04661

CERTIFICATE OF DEATH

04660

Item 23b Film 0311 1/26/62 mh

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 3 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Pennsylvania		b. COUNTY Philadelphia		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Philadelphia		d. STREET ADDRESS 3048 N. 9th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Irene Margaret Baker		First		Middle		Last		4. DATE OF DEATH April 17, 1962		Month		Day		Year			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH November 5, 1906		9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME John Gundaker		14. MOTHER'S MAIDEN NAME Mary Gray															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mary Gray		Address											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac tamponade 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Rheumatic valvulitis, inactive, with mitral stenosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)												INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hours 20 years					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Bethesda		(County) Montgomery		(State) Md.							
21. I certify that (he/she) attended the deceased from April 14, 1962 to April 17, 1962 , that (he/she) saw the deceased alive on April 17, 1962 , and that death occurred at 1:00 PM from the causes and on the date stated above.																	
22a. SIGNATURE Lewis N. Cahill												M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) LEWIS N. CAHILL LT MC USN												22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 23, 1962		23c. NAME OF CEMETERY OR CREMATORY Beverly National		23d. LOCATION (City, town or county) Beverly, New Jersey		(State) New Jersey									
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey												ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR APR 23 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Thoma	
Robert A. Pumphrey Funeral Home, 7557 Wisc. Ave.,																	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04662

04661

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY in 1b 25 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 5406 McKinley Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Jonathan Middle J. Last Baker		4. DATE OF DEATH Month April Day 27 Year 1962		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 1, 1898		9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 63 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Maryland				11. BIRTHPLACE (County & State, or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Baker				14. MOTHER'S MAIDEN NAME Roslie Henderson				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 578-46-6800				17. INFORMANT David Baker Address same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO (b) myocardial infarct Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																INTERVAL BETWEEN ONSET AND DEATH 3 weeks 4 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from March 29, 1962, to April 27, 1962, that (I) (we) last saw the deceased alive on April 28, 1962, and that death occurred at 5:00 P.M. from the causes and on the date stated above.																			
22a. SIGNATURE 												22b. DATE SIGNED APR 30 '62							
22c. PHYSICIAN'S NAME (Type) W. H. K. Hax												22d. ADDRESS 8218 Wisconsin Ave. Bethesda							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4/30/62				23c. NAME OF CEMETERY OR CREMATORY Rockville				23d. LOCATION (City, town or county) (State) Rockville, Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home												25a. REC'D BY REGISTRAR APR 30 '62				25b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CHAND

Montgomery

Beethoven

Shubert Hospital

Jon. Ann

White

Unpublished

John Baker

No

575-5-5800 David Baker

same as above

Montgomery

Beethoven

Shubert Hospital

Jon. Ann

White

Unpublished

John Baker

U.S.A.

CHAND

Montgomery

Beethoven

Shubert Hospital

Jon. Ann

White

Unpublished

John Baker

No

575-5-5800 David Baker

same as above

Montgomery

Beethoven

Shubert Hospital

Jon. Ann

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John Baker

No

575-5-5800 David Baker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04663

04662

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>1081 Ruatan Street</u>		d. STREET ADDRESS <u>1081 Ruatan Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Virgil</u> Middle <u>Lee</u> Last <u>Bankson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 24, 1908</u>
9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>14</u> Hours <u>14</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Economist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Department</u>	11. BIRTHPLACE (State or foreign country) <u>Park, Kansas</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles W. Bankson</u>		14. MOTHER'S MAIDEN NAME <u>Ella May Green</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Ross R. Bankson 1081 Ruatan St, Silver Spring, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - Transverse Colon</u> DUE TO <u>193.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>193.1</u> (c) <u>193.1</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Uncertain</u> <u>Probably 5 or 6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/21</u> 19 <u>61</u> to <u>4/14</u> 19 <u>62</u> that (I) (<u>was</u>) last saw the deceased alive on <u>4/13</u> 19 <u>62</u> and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>A. B. Little</u>		22b. DATE SIGNED <u>4/14/1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. B. LITTLE, M.D.</u>		22d. ADDRESS <u>6911 5th St, NW Washington, D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-17-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Prince George's Co., Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Warner</u>		25a. REC'D BY REGISTRAR <u>APR 17 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur E. Kiser</u>			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

DATE

1911

DECEASED

AT

PLACE

1911

NAME

AGE

SEX

DATE

PLACE

NAME

AGE

SEX

DATE

PLACE

NAME

AGE

SEX

DATE

PLACE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04664

04663

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in 1b <u>3 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>47X-3</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>105 Rittenhouse St. N.E.</u> d. STREET ADDRESS <u>105 Rittenhouse St. N.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>FRED</u> Last <u>Barner</u>			4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1962</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>April 8, 1887</u>		9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>74</u> Days <u>74</u> IF UNDER 24 HRS. Hours <u>74</u> Min. <u>74</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard Retired U.S. Government</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania</u>		11. BIRTHPLACE (County & State, or foreign country) <u>America</u>			
13. FATHER'S NAME <u>Matthew Barner</u>			14. MOTHER'S MAIDEN NAME <u>MARY Stein</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(Yes give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>579-09-7857</u>		17. INFORMANT <u>Washington Hospital Record.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446 X</u> <u>Azotemia</u> DUE TO (b) <u>Nephrosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis & hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Plural effusion and pulmonary edema</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> <u>5 yrs</u> <u>12 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I (a) <u>Plural effusion and pulmonary edema</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> e.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <u>Dec 1961</u>		20g. (County) <u>April 1, 1962</u>		20h. (State) <u>11:50 M.</u>			
21. I certify that (I) (this hospital) attended the deceased from... Dec 1961 to April 1, 1962 that (I) (we) last saw the deceased alive on... April 1, 1962 and that death occurred at... 11:50 M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Samuel M. Bageant</u> M.D.				22b. DATE SIGNED <u>4/2/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>Samuel M. Bageant</u>				22d. ADDRESS <u>5600 New Hampshire Ave. N.E.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>4/4/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem. Ft. Myer, Va.</u>			
23d. LOCATION (City, town or county) <u>2901 14th St. N.W.</u>		23e. REC'D BY REGISTRAR <u>APR 5 '62</u>		23f. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. Washington 9, D.C.</u>							



01062

CHRYSLER F. DEATH

00884

[Faint, mostly illegible handwritten text, possibly a letter or document, with some words like "Dear" and "Yours" visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed in by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04664

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>2 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1000 Daleview Drive</u> <u>Althea Woodland Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>---</u> b. COUNTY <u>---</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> d. STREET ADDRESS <u>4000 Cathedral Avenue, N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Catherine Barrett</u> <u>Mary Catherine Barrett</u>		4. DATE OF DEATH <u>April 10,</u> 19 <u>62</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/23/1872</u>
9. AGE (in years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u>	IF UNDER 24 HRS. Hours <u>---</u> Min. <u>---</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Louisville, Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Barrett</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Flynn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Florence Huebner</u>		Address <u>4000 Cathedral Ave., N.W.</u> <u>Washington, D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anemia</u> DUE TO <u>Pyelonephritis, chronic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Debilitated mellitus</u> DUE TO (c) <u>---</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Anemia, Secondary & Emphysema pulmonary senile</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>also arterio-sclerotic heart disease</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>---</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>10 April, 1962</u> that (I) (we) last saw the deceased alive on <u>8 April, 1962</u> and that death occurred at <u>12:37 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Harry A. Horstman, Jr.</u>		22b. DATE SIGNED <u>10 April 62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Harry A. Horstman, Jr.</u>		22d. ADDRESS <u>915 - 19th St. NW Wash DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>4/11/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Louisville, Kentucky</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Miller Co.</u>		25a. REC'D BY REGISTRAR <u>2900 14th St. N.W.</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>
DATE <u>APR 12 '62</u>		DATE <u>APR 12 '62</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04666

CERTIFICATE OF DEATH

04665

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring, c. LENGTH OF STAY IN 1b 3 weeks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bel Pre Nursing Home, 2601 Bel Pre Rd.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 3028 Kingtree St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Louise Baumgartner				4. DATE OF DEATH Month Day Year April 7 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 13, 1873	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (County & State, or foreign country) Wisconsin	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Stroy				14. MOTHER'S MAIDEN NAME Johanna Kupke			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No None				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Donald Kinsinger 10,620 Ga. Ave., Silver Spg. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease DUE TO 10 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Congestive Heart Failure DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arterio Sclerosis INTERVAL BETWEEN ONSET AND DEATH 10 years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 10 1956 to April 7 1962 that (I) (we) last saw the deceased alive on Mar 7 1962 and that death occurred at 8 AM , from the causes and on the date stated above.							
22a. SIGNATURE John J. Curry M.D.				22b. DATE SIGNED 4/7/62			
22c. PHYSICIAN'S NAME (Type) John J. Curry				22d. ADDRESS 10620 Georgia Ave. S.S.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Wed. Apr. 11, 1962		23c. NAME OF CEMETERY OR CREMATORY Lutheran Trinity Evangelical		23d. LOCATION (City, town or county) (State) Murdock, Nebr.	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY INC. 8434 Georgia Ave.,				25. REC'D BY REGISTRAR DATE APR 11 '62			
25b. REGISTRAR'S SIGNATURE Arthur S. Thana							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04667

04666

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u> d. STREET ADDRESS <u>400 N. 2nd St. Lot 38</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MR. Walter Stanley BEADLES</u>		4. DATE OF DEATH <u>April 19 1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-25-97</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>America</u>		13. FATHER'S NAME <u>Robert Beadles</u>	
14. MOTHER'S MAIDEN NAME <u>Florence Mitchell</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WW I</u>	
16. SOCIAL SECURITY NO. <u>157X</u>		17. INFORMANT <u>Patient's CHART</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia, b/c nephroses</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Obstruction of common bile duct</u> (c) <u>Carcinoma of head of pancreas</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Laurel</u> (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/23/1956</u> to <u>4/19/1962</u> that (I) (we) last saw the deceased alive on <u>4/19/1962</u> and that death occurred at <u>4:10 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Howard I. [Signature]</u>		22b. DATE SIGNED <u>4/19/62</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>7030 Carroll Ave Takoma Park, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/24/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town or county) <u>Arlington</u> (State) <u>Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Gasch's Sons</u>		25a. REC'D BY REGISTRAR <u>APR 24 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>			

01880

RECEIVED AT W. D. LATH

01880



Francis G. Smith & Sons, Haverhill, Md.

1/25/65

Arlington National

Arlington

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04668

04667

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47 Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7424 Exeter Road		d. STREET ADDRESS 1 7424 Exeter Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Agnes W. T. Beall		4. DATE OF DEATH Month Day Year April 6 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 29, 1869
9. AGE (In years last birthday) 92 yrs.		10. IF UNDER 1 YEAR Months 8 Days 7 Hours Min. 	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John B. Thomas		14. MOTHER'S MAIDEN NAME Ann Emmert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT same 2d Address Emmert Beall-son-Bethesda, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant cachexia DUE TO 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF STOMACH DUE TO (c) 14 MONTHS		INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JULY 21 1952 to APRIL 19 62 that (I) (we) last saw the deceased alive on APRIL 6 19 62 and that death occurred at 1:00 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Robert G. Angle		22b. DATE SIGNED 4/6/62	
22c. PHYSICIAN'S NAME (Type) Robert G. Angle		22d. ADDRESS Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/9/62	
23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR APR 9 1962	
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

23

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04670 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04669											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>years</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>18 Takoma Park</u>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7300 Birch Ave</u>						d. STREET ADDRESS <u>7300 Birch Ave</u>					
3. NAME OF DECEASED (Type or print) <u>Horace Wilson Bennett Jr.</u>						4. DATE OF DEATH Month <u>Apr</u> Day <u>13</u> Year <u>1962</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-8-1907</u>		9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u>54</u> Days <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Notary Public - Bookkeeper - Office Mgr</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Horace W. Bennett</u>						14. MOTHER'S MAIDEN NAME <u>Columbia E. Richter</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)						16. SOCIAL SECURITY NO. <u>272-14-3120</u>		17. INFORMANT <u>Mary Bennett (wife)</u> Address <u>8807 Glenville Rd, Silver Spring, md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage & laceration</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Shot gun wound thru skull</u> DUE TO (c) <u>Sudden</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted shot gun wound - 20 gauge</u>					
20c. TIME OF INJURY Month, Day, Year <u>11 a.m. 4-13 1962</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Takoma Park</u>		20g. (County) <u>Montg</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschant</u>						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>4-13-62</u>					
Address (Street, city, town, or county) <u>254 Carroll St NW Wash. D.C.</u>						22a. REC'D BY REGISTRAR DATE <u>APR 18 '62</u>					
22b. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>April 16, 1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Neelsville Cemetery</u>				22d. LOCATION (City, town, or country) (State) <u>near Germantown - Mont. Co. Maryland</u>	
23. FUNERAL DIRECTOR <u>Arthur Walters</u>						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04671

04670

1. PLACE OF DEATH e. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE Virginia b. COUNTY Arlington			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Arlington			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Resmor Sanitarium				d. STREET ADDRESS 1135 South Thomas Street			
3. NAME OF DECEASED (Type or print) Lily Ellen BENNING				4. DATE OF DEATH April 2 19 62			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 25, 1874	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR 7 Months 7 Days		IF UNDER 24 HRS. 7 Hours 7 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Canada	
12. CITIZEN OF WHAT COUNTRY? Canada							
13. FATHER'S NAME Nicholas P. Benning				14. MOTHER'S MAIDEN NAME Mary O'Brien			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Albert Parks, Nephew				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Myocardial infarction DUE TO extension previous myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Anteriosclerotic heart disease severe DUE TO Diabetes Mellitus				INTERVAL BETWEEN ONSET AND DEATH 10 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Month 22, 1962 to April 2, 1962 that (I) (we) last saw the deceased alive on April 2, 1962 and that death occurred at 7:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE George H. Mitchell M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED April 3, 1962	
22c. PHYSICIAN'S NAME (Type) George H. Mitchell				22d. ADDRESS 10620 Georgia Ave., Silver Spring Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit		23b. DATE THEREOF 4/5/62		23c. NAME OF CEMETERY OR CREMATORY Paris Cemetery		23d. LOCATION (City, town or county) (State) Paris, Ontario Canada	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland				25a. REC'D BY REGISTRAR APR 6 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



0160

04671

Montgomery

Berkeley

Sanitarium

115

Ellen

Brown

April 2

Aug. 22, 1874 87

Kennie White

None

None

Canada

Canada

Nicholas P. Higgins

Mary O'Brien

None

Albert R. R. R.

My dear friend

I have just received your letter

and am glad to hear from you

I am well and hope this finds you the same

Yours truly

George H. Mitchell

George H. Mitchell

10050 Georgia Ave. Silver Spring Md.

Robert A. Humphrey, Berkeley, Maryland

1
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04672 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04671

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Montg.</i>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Elkridge</i>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Box 39 - Laurel 19 (rural)</i>				
c. LENGTH OF STAY IN 1b <i>DOA.</i>					d. STREET ADDRESS <i>Greencastle Rd</i>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Montg. Gen. Hosp.</i>					a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>William Edward Birch</i>					4. DATE OF DEATH <i>Apr. 6 1962</i>				
5. SEX <i>male</i>					6. COLOR OR RACE <i>white</i>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <i>2-4-62</i>				
9. AGE (In years last birthday) <i>0</i> yrs. <i>2</i> months <i>2</i> days					IF UNDER 1 YEAR <i>2</i> months <i>2</i> days				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (State or foreign country) <i>md</i>					12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>Robert Birch</i>					14. MOTHER'S MAIDEN NAME <i>Dorothy Morris</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.				
17. INFORMANT <i>Dorothy Birch (mother)</i>					Address <i>Stuen 2</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxia</i> <i>475X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>upper Respiratory Infection</i> DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
DATE SIGNED <i>4-6-62</i>									
ACTUAL SIGNATURE <i>Frank J. Broschak</i> M.D.									
EXAMINER'S NAME (Type) <i>FRANK J. BROSCHAK</i>									
Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>									
22b. DATE THEREOF <i>April 7, 1962</i>									
22c. NAME OF CEMETERY OR CREMATORY <i>Sanage Cemetery</i>									
22d. LOCATION (City, town, or country) (State) <i>Sanage Md</i>									
23. FUNERAL DIRECTOR <i>DeWitt Donaldson, Laurel, Md</i>									
ADDRESS									
24a. REC'D BY REGISTRAR <i>APR 11 '62</i>									
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>									

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2-007798

1971

1971

(M)

(M)

(M)

(M)

(M)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

FOR STATE
HEALTH DEPT.

M

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2

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		a. STATE		b. COUNTY	
Montgomery		Takoma Park		Md		mont	
MARYLAND		DOA		X Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Wash. San. & Hosp		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year	
Raymond Burke Boyle		Boyle		Apr 3 1962			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH	
Male		White				8-9-14	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
47 yrs.		Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Tourist guide		Gray Lines		Wash. DC		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Joseph Emery Boyle		Delia Finnegan					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year and dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
Yes		WW II		579-05-4543		MRS. Patricia B Boyle	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		4-20-1		DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		Cormary occlusion		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE Frank J. Broschert		M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		4-3-62	
EXAMINER'S NAME (Type) FRANK J. Broschert		Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
Burial		4-6-62		St. John's Cemetery		Forest Glen Montgomery Co, Maryland	
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Raymond A. Ziska		8434 Georgia Ave.		APR 6 '62		Arthur S. Kraus	
Warner E. Humphrey, Inc.		Silver Spring, Maryland		DATE			

04678

1073

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4-4-52

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be completed by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04674

04673

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> c. LENGTH OF STAY IN 1b <u>70 Yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>07 Gaithersburg</u> d. STREET ADDRESS <u>12 Park Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Cleveland</u> Last <u>Briggs</u>				4. DATE OF DEATH Month <u>Apr</u> Day <u>18th</u> Year <u>1962</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 28-1891</u>		9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>10</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Government Clerk,</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME <u>James M.W. Briggs</u>				14. MOTHER'S MAIDEN NAME <u>Drusilla Snyder.</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT as <u>2</u> Address <u>Mrs Nannie R. Briggs. Gaithersburg, Md.</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIAL HYPERTENSION</u> DUE TO <u>GENERALIZED ARTERIOSCLEROSIS</u> (c) <u>DIABETES MELLITUS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>												INTERVAL BETWEEN ONSET AND DEATH <u>ONE HOUR</u> <u>30 YEARS</u> <u>30 YEARS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour a.m. <u></u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u>		(County) <u></u>		(State) <u></u>					
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 1956</u> to <u>APRIL 18, 1962</u> that (I) (we) last saw the deceased alive on <u>MARCH 10, 1962</u> and that death occurred at <u>10:45 PM</u> from the causes and on the date stated above.															
22a. SIGNATURE <u>Gordon Rosenberg</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>April 18, 1962</u>							
22c. PHYSICIAN'S NAME (Type) <u>Gordon Rosenberg</u>				22d. ADDRESS <u>310 W. Montgomery and Rockville, Maryland</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Apr 21-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>				23d. LOCATION (City, town or county) <u>Gaithersburg, Md.</u> (State) <u></u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner. Gaithersburg, Md.</u>				ADDRESS <u></u>				25a. REC'D BY REGISTRAR <u>APR 23 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thiele</u>					

01373

UNITED STATES OF AMERICA

OFFICE

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FOR STATE
HEALTH DEPT.
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TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
04674											
1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Silver Spring d. STREET ADDRESS Route 2							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 10				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium and Hospital											
3. NAME OF DECEASED (Type or print) First Middle Last Bessie Lillian Bruce				4. DATE OF DEATH Month Day Year April 26 1962							
5. SEX F		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 15, 1923		9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? American	
13. FATHER'S NAME James Black				14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Hospital Record Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 825X Pulmonary embolism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Multiple injuries, extensive (c) Auto accident PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH sudden 9 days											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was passenger in car involved in accident							
20c. TIME OF INJURY Hour Minute Month, Day, Year 4:35 p.m. 4-17 1962				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. R-29			
20f. (City or town) Spencerville Monty Md				20g. (County) Montgomery				20h. (State) Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Frank J. Broschart				M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 4-26-62			
EXAMINER'S NAME (Type) FRANK J. Broschart				Address (Street, city, town, or county) Rockville, Md.							
22a. BURIAL, CREMATION, REBURY (Specify) Burial				22b. DATE THEREOF 4/29/62				22c. NAME OF CEMETERY OR CREMATORY Piney Hill Church.,			
22d. LOCATION (City, town, or country) Amherst, Va.											
23. FUNERAL DIRECTOR Robert L. Snowden				ADDRESS Rockville, Md.				24a. REC'D BY REGISTRAR DATE MAY 1 '62			
								24b. REGISTRAR'S SIGNATURE Arthur S. Kram			

04654

85312

(M)

1

May 11 1961

1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04675

CERTIFICATE OF DEATH

04675

Item 8 Film G311 4/26/62 mh

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Mont. Co.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY in 1b 27 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 45 Bethesda		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban				d. STREET ADDRESS 5605- Sonoma Rd.			
3. NAME OF DECEASED (Type or print) First Anna Middle M. Last Brunssen				4. DATE OF DEATH Month April Day 16 Year 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1877	
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 10 Days 16 Hours 19 Min. 62		11. BIRTHPLACE (County & State, or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Private		11. BIRTHPLACE (County & State, or foreign country) Germany	
13. FATHER'S NAME John Nickel				14. MOTHER'S MAIDEN NAME Elizabeth Einway			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no				16. SOCIAL SECURITY NO. no			
17. INFORMANT Margaret Whedon /s ame as above				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Broncho pneumonia DUE TO 4-4-2X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Congestive heart failure (c) Arteriosclerotic, hypertensive heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Rheumatoid arthritis, psoriasis							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. Month, Day, Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1955 to 4-16-1962 , that (I) (we) last saw the deceased alive on 4-16-1962 , and that death occurred at 6:15 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Dorothy Gill				22b. DATE SIGNED APR 19 1962			
22c. PHYSICIAN'S NAME (Type) Dorothy Gill, M.D.				22d. ADDRESS 7511 Arlington Rd., Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit		23b. DATE THEREOF 4/18/62		23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		23d. LOCATION (City, town or county) (State) Westchester Co. New York	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25. REC'D BY REGISTRAR APR 19 1962	
25b. REGISTRAR'S SIGNATURE Arthur S. Hump							

04375

04375

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE ASSISTANT SECRETARY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it is to be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04677 Item 23b, Film G511 4/13/62 iwk											
04676											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lanham d. STREET ADDRESS Box 364, Goodluck Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Ada Middle Virginia Last Burbage						4. DATE OF DEATH Month April Day 5 Year 1962					
5. SEX Female		6. COLOR OR RACE Caucasion		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-29-06		9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ernest Donaldson						14. MOTHER'S MAIDEN NAME unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 218-24-0699		17. INFORMANT Robert E. Burbage (son) Address 6301 93rd Ave., Lanham, Md					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Cerebral Hemorrhage (c) Hypertension										INTERVAL BETWEEN ONSET AND DEATH 4 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that NO (this hospital) attended the deceased from April 5, 1962 to April 5, 1962 , that it (we) last saw the deceased alive on April 5, 1962 , and that death occurred 9:25 PM from the causes and on the date stated above.											
22a. SIGNATURE William F. Cavender M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED April 5, 1962			
22c. PHYSICIAN'S NAME (Type) William F. Cavender, LT MC USN						22d. ADDRESS U. S. Naval Hospital, Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF April 10, 1962		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons Funeral Home,						25a. REC'D BY REGISTRAR APR 9 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Thoma			

141

Bohannon (Muriel)

U. S. Naval Hospital

Box 15, Goodrich Rd.

Age

Virginia

Barbara

April

Female

Chenosis

x

12-23-00

25

Monrovia

Washington, D.C.

U.S.A.

Private Hospital

Unknown

No

Respiratory Failure

Cardiac Neurosis

Hypertension

April 2, 1962

9:25PM

William F. Conover

William F. Conover, Jr. MD MS

U. S. Naval Hospital, Bethesda, Maryland

Washington National

Clinton, Virginia

1111 1/2 West 11th St., N.W.

Atlanta, Georgia 30303

04672

MEDICAL CERTIFICATION

16678

CERTIFICATE OF DEATH

01877

71

0.

PHOSPHOR

John F. 1917

1-2-12

1-2-12

DEATH

DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
04678											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY in 1b <u>D.O.A.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>53 Chevy Chase</u>				d. STREET ADDRESS <u>29 W. Irving St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>Hillery</u> Last <u>Burrows</u>						4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>1962</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/12/1889</u>		9. AGE (In years last birthday) <u>72 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Concrete const.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Robert Burrows</u>						14. MOTHER'S MAIDEN NAME <u>Harriet Powers</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>						16. SOCIAL SECURITY NO. <u>218-30-3857</u>		17. INFORMANT <u>Raymond R. Burrows</u> Address <u>10906 Reswick Rd.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary artery insufficiency</u>											
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <u>Severe coronary artery atherosclerosis</u>											
(c) <u> </u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
<u>Antero septal myocardial infarction, extensive, healed.</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was driver of car which left highway</u>							
20c. TIME OF INJURY Month, Day, Year <u>3:00 p.m. 4-5-1962</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) <u>Bethesda</u>		(County) <u>Montgomery</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <u>4-6-62</u>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Address (Street, city, town, or county) <u> </u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4/9/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>				22d. LOCATION (City, town, or country) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>						24a. REC'D BY REGISTRAR <u>APR 9 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

04328

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St. John's Hospital

B.O.B.

St. John's Hospital

Handwritten text, mostly illegible due to fading and bleed-through.

Robert A. Humphrey, Bethesda, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04680
04679

CERTIFICATE OF DEATH

Item 9 Film G310 4/9/62 iwk

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 41 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia		b. COUNTY Lexington	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS Blueridges, Rt. #4		g. DATE OF DEATH April 3, 1962		h. MONTH April 3, 1962	
3. NAME OF DECEASED (Type or print) Charles William Anthony Campbell		4. DATE OF DEATH April 3, 1962		5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH July 16, 1883		9. AGE (In years last birthday) 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Naval Officer		11. BIRTHPLACE (County & State, or foreign country) North Dakota		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Campbell		14. MOTHER'S MAIDEN NAME Elizabeth T. Hughes		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes		16. SOCIAL SECURITY NO. Hospital Records		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4-20-00 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) ASHD (c) Carcinoma, Prostate		INTERVAL BETWEEN ONSET AND DEATH 15 min 10 yrs 2 weeks		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Lexington		(County) Lexington	
20g. (State) Virginia		20h. (City or town) Lexington		20i. (County) Lexington		20j. (State) Virginia		20k. (City or town) Lexington	
20l. (County) Lexington		20m. (State) Virginia		20n. (City or town) Lexington		20o. (County) Lexington		20p. (State) Virginia	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 22, 1962 , to April 3, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 3, 1962 , and that death occurred at 12:15 PM on the causes and on the date stated above.		22a. SIGNATURE H. S. Irons		22b. DATE April 4, 1962		22c. PHYSICIAN'S NAME (Type) H. S. IRONS LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-5-62		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) Arlington, Virginia		(State) Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR APR 6 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas		24c. ADDRESS Bethesda, Md.		24d. DATE APR 6 '62	

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Virginia

Virginia

Washington

AI days

Washington (Rural)

U. S. Naval Hospital

Washington, DC

Charles William Campbell

Medical

July 15, 1955

Medical Naval Officer

North Dakota

Charles Campbell

Elizabeth T. Hughes

Hospital Records

Yes

February 22, 1955

12:15 PM

April 3

April 5, 1955

U. S. House of Representatives

U. S. Naval Hospital, Bethesda, MD

Arlington, Virginia

Arlington Hospital

4-5-55

Bureau

Bethesda, MD

Robert A. Thompson, Federal Home, 1551 Wisconsin Ave., N.W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body. Pages 3 and 4 should be filed with the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04682

CERTIFICATE OF DEATH

04681

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN IS 21 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Seat Pleasant d. STREET ADDRESS 7612 D Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ann Middle Marie Last Carter		4. DATE OF DEATH Month April Day 17 Year 19 62	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 23, 1900	
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Foran		14. MOTHER'S MAIDEN NAME Mary Hand	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unascertainable	
17. INFORMANT The Medical Records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma of endometrium DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. INTERVAL BETWEEN ONSET OF DEATH 1 day		20. 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from March 27, 1962 to April 17, 1962 that (1) (we) last saw the deceased alive on April 17, 1962 , and that death occurred at 5:45 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Richard S. Rivlin M.D.		22b. DATE SIGNED April 18, 1962	
22c. PHYSICIAN'S NAME (Type) Richard S. Rivlin, M.D.		22d. ADDRESS The Clinical Center, National Institutes Of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee - Wash. D. C.		25a. REC'D BY REGISTRAR APR 23 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Hanes			



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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04683

04682

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Germantown c. LENGTH OF STAY IN 1b Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Box 47		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Germantown d. STREET ADDRESS Box 47 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THERESA Middle LYNN Last CAVELL		4. DATE OF DEATH Month April Day 30 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 March 1962
9. AGE (In years last birthday) 1 Months 4 Days 4 Hours Min. 		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	
11. BIRTHPLACE (County & State, or foreign country) Frederick, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur L. Cavell		14. MOTHER'S MAIDEN NAME Charlotte Evelyn Nusbaum	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Arthur L. Cavell (Same as item #1)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492X DUE TO Virus pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) 		INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. 19 p.m. 	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 4-30-1962 to 4-30-1962 , that (I) (we) last saw the deceased alive on 4-30-1962 , and that death occurred at 9:30P , from the causes and on the date stated above.			
22a. SIGNATURE Rex R. Martin M.D.		22b. DATE SIGNED 1 May 1962	
22c. PHYSICIAN'S NAME (Type) Rex R. Martin, M. D.		22d. ADDRESS 220 N. Market St., Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-3-62	23c. NAME OF CEMETERY OR CREMATORY Baptist Cemetery	23d. LOCATION (City, town or county) (State) Germantown, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR MAY 3 '62	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
04684 Item 8FilmG310 4/9/62 iwk													
04683													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>D.C.</u> b. COUNTY <u>✓</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>							
c. LENGTH OF STAY IN 1b <u>2 1/2</u> days						d. STREET ADDRESS <u>3213 Wisconsin Ave. N.W.</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SUBURBAN HOSP.</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Norma</u> Middle <u>N.</u> Last <u>Chappell</u>						4. DATE OF DEATH (Apt. # 23) <u>April 2 19 62</u>							
5. SEX <u>Female</u>						6. COLOR OR RACE <u>White</u>							
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>10/23/64 1893</u>							
9. AGE (In years last birthday) <u>68</u> yrs.						10. IF UNDER 1 YEAR Months <u>6</u> Days <u>2</u> Hours <u>62</u> Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Kentucky</u>							
11. BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Wm. Monroe Bradley</u>						14. MOTHER'S MAIDEN NAME <u>Martha Jordan</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>						16. SOCIAL SECURITY NO. <u>no</u>							
17. INFORMANT <u>chart</u>						Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture, heart, interventricular septum</u> DUE TO <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>72 hours</u> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u>						20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>3-30</u> , 19 <u>62</u> to <u>4-2</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>4-2</u> , 19 <u>62</u> and that death occurred at <u>M</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Peter P. Andrews</u>						22b. DATE SIGNED <u>4-2-62</u>							
22c. PHYSICIAN'S NAME (Type) <u>Peter P. Andrews</u>						22d. ADDRESS <u>4801 FESSENDEN ST N.W. D.C.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						23b. DATE THEREOF <u>4-4-62</u>							
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>						23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Choy Chase Funeral Home</u>						25a. REC'D BY REGISTRAR <u>APR 5 '62</u>							
ADDRESS <u>5101 Wisconsin Ave. N.W.</u>						25b. REGISTRAR'S SIGNATURE <u>Wm. S. Thomas</u>							

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FOR-STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04684

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Monty</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>			
c. LENGTH OF STAY in lb <i>2 1/2 yrs</i>				d. STREET ADDRESS <i>5734 Crawford Dr</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>5734 Crawford Dr</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Agnes Ann Chinnick</i>				4. DATE OF DEATH Month <i>Apr</i> Day <i>8</i> Year <i>1962</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1-17-01</i>	
9. AGE (in years last birthday) <i>61</i> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>				11. BIRTHPLACE (State or foreign country) <i>Poland</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>							
13. FATHER'S NAME <i>Michael Dengow</i>				14. MOTHER'S MAIDEN NAME <i>Josephine Schudlewsk</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>None</i>			
17. INFORMANT <i>Leona Von Bretzel - Rockville md</i>				Address <i>13504 Bailey Dr</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>C.A. Left breast - 6 mos.</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschant</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>FRANK J. Broschant</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>Apr 8 1962</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>4/11/62</i>			
22c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cem.</i>				22d. LOCATION (City, town, or country) (State) <i>Silver Spring, Maryland</i>			
23. FUNERAL DIRECTOR <i>Robert A. Pumphrey, Bethesda, Maryland</i>				24e. REC'D BY REGISTRAR <i>APR 13 '62</i>			
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>			

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177-61

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Robert A. Johnson, Secretary, 177-61

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FOR STATE
HEALTH DEPT. (M)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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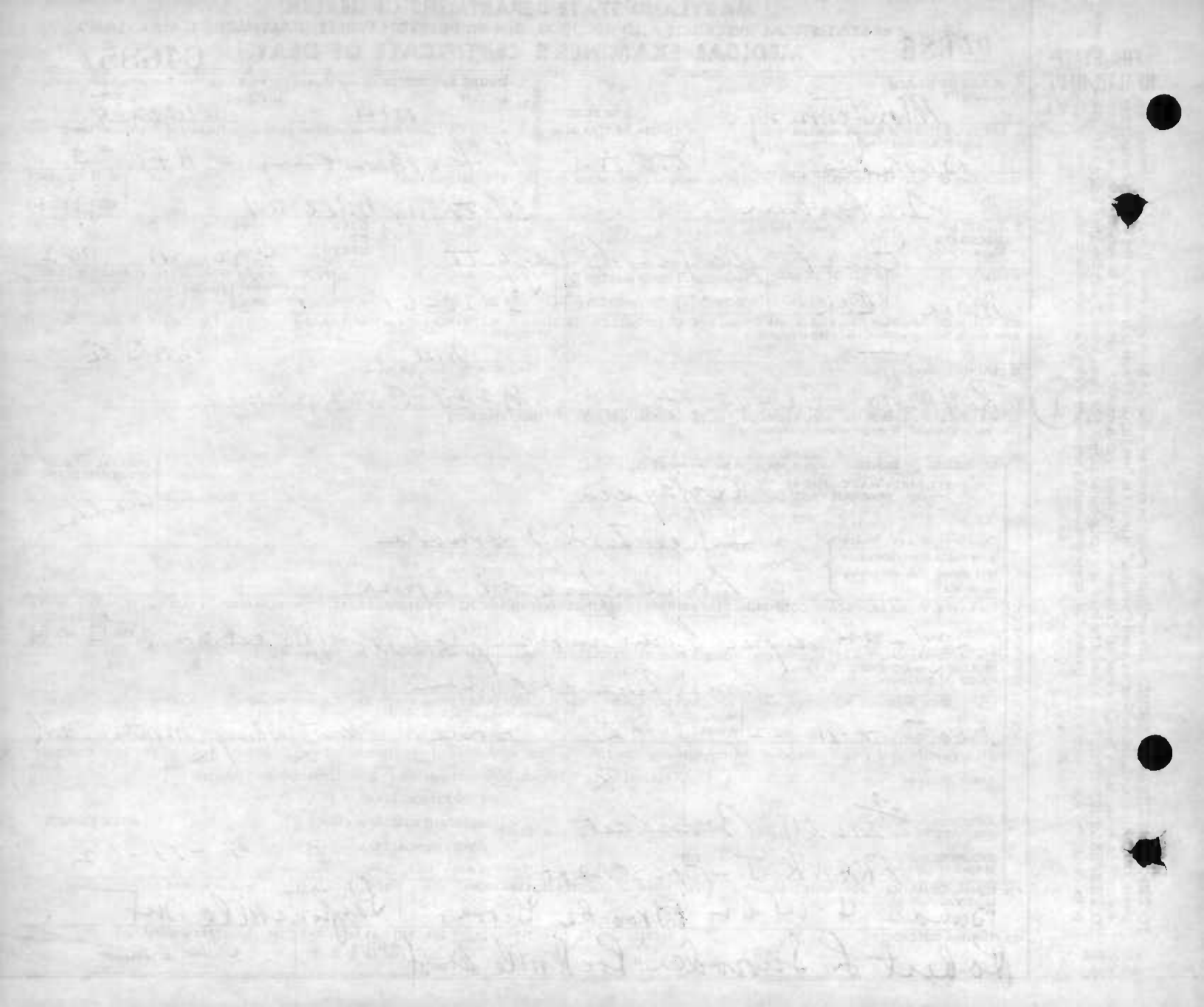
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MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04685											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>08 Gaithersburg - RTU #3</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>						d. STREET ADDRESS <u>Watkins Mill Rd.</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>David Wayne Claggett</u>						4. DATE OF DEATH Month Day Year <u>Apr 11 1962</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-20-61</u>		9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>RONALD CLAGGETT</u>						14. MOTHER'S MAIDEN NAME <u>MARY CAMPBELL</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 916.0 DUE TO <u>Inhalation of smoke</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>house fire at home</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2nd + 3rd degree burns involving chest-upper ext. of face</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, item 18.) <u>house fire at home</u>											
20c. TIME OF INJURY Month, Day, Year Hour <u>1:30</u> p.m. <u>4-11</u> 19 <u>62</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) <u>Gaithersburg</u> (County) <u>Monty</u> (State) <u>md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Blosshart</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. Blosshart</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>4-14-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Broke Grove</u>		22d. LOCATION (City, town, or country) (State) <u>Daytonville, Md</u>	
23. FUNERAL DIRECTOR <u>Robert L. Suoroder</u> ADDRESS <u>Rockville Md</u>						24a. REC'D BY REGISTRAR <u>APR 19 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thayer</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04687

CERTIFICATE OF DEATH

04686

Item 21 Film 511 4/15/62 iwk

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN TB 4 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Florida b. COUNTY Tampa c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 48X-3 d. STREET ADDRESS 5013 - 28th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Linda Marie Clark		First Linda Middle Marie Last Clark		4. DATE OF DEATH April 9, 1962			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 24 February 1954		9. AGE (In years last birthday) 8 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 36 hours			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Florida			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Kelly		14. MOTHER'S MAIDEN NAME Virginia Clark			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 204-3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia -- Cardiac Failure DUE TO (c) Acute Lymphocytic Leukemia 6 weeks				INTERVAL BETWEEN ONSET AND DEATH Immediate			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Tampa		20g. (County) Florida		20h. (State) Florida			
21. I certify that (I) (this hospital) attended the deceased from April 5, 1962 , to April 9, 1962 , that (I) (we) last saw the deceased alive on April 9, 1962 , and that death occurred at 7:15 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Robert H. Levin M.D.		22b. DATE SIGNED April 9, 1962		22c. PHYSICIAN'S NAME (Type) Robert H. Levin, M.D.			
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) April 19, 1962		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			
23d. LOCATION (City, town or county) Tampa, Florida							
24. FUNERAL DIRECTOR'S SIGNATURE Tragie's Funeral Home, 389-R.S. Ave. N.W. Wash. D.C.		25a. REC'D BY REGISTRAR APR 12 '62		25b. REGISTRAR'S SIGNATURE Christina S. Hume			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04688

04687

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SANITARIUM + Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>18 Takoma Park, MD.</u> d. STREET ADDRESS <u>410 Philadelphia Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Grace Winner Close</u>		4. DATE OF DEATH <u>April 18</u> 1962		5. SEX <u>fe</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 28, 1898</u>		9. AGE (In years last birthday) <u>63</u> yrs. IF UNDER 1 YEAR Months <u>11</u> Days <u>21</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Artist Illustrator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Andrew Jackson Albertson Winner</u>				14. MOTHER'S MAIDEN NAME <u>Annie Kate Roller</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>pts. son</u>					
16. SOCIAL SECURITY NO. <u></u>				17. INFORMANT <u>MORACE W. Close</u> Address <u>Same as above.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4-20-62</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. DUE TO (c) <u></u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>									
2Dc. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u></u> p.m. <u></u>				2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		2Df. (City or town) <u></u> (County) <u></u> (State) <u></u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>4-18-62</u>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) <u></u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>4/21/1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL MEMORIAL PARK</u>		22d. LOCATION (City, town, or country) (State) <u>FALLS CHURCH, VIRGINIA</u>					
23. FUNERAL DIRECTOR <u>Martin W. Young Company</u>				ADDRESS <u>1300 N. Street, N.W.</u>				24a. REC'D BY REGISTRAR <u>APR 23 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04689

CERTIFICATE OF DEATH

04688

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 102 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE North Dakota b. COUNTY Fargo c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 1223 S. Tenth Street d. STREET ADDRESS 71X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Ray Harold Coffman				4. DATE OF DEATH Month Day Year April 7, 19 62			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 27, 1918 43 yrs.	
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days 3 10 13		IF UNDER 24 HRS. Hours Min. 10 15		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreign Service Officer	
11. BIRTHPLACE (County & State, or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Harold Coffman		14. MOTHER'S MAIDEN NAME Aletha Marrow	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma 162.1 Conditions, if any, which gave rise to immediate cause (b) 162.1 (a), stating the underlying cause last. (c) 162.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 162.1						INTERVAL BETWEEN ONSET AND DEATH 3 mo	
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 62		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 10 (this hospital) attended the deceased from December 26, 1961 , to April 7, 1962 , that 1 (we) last saw the deceased alive on April 7, 1962 , and that death occurred 7:30 PM from the causes and on the date stated above.							
22a. SIGNATURE Vern N. Houk 22c. PHYSICIAN'S NAME (Type) Vern N. Houk LCDR MC USN				22b. DATE SIGNED April 8, 1962 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 4-10-62		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION (City, town or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE W. William Lee's Sons Co. Funeral Home 4th & Mass. Ave., Wash. D.C.				25. REC'D BY REGISTRAR APR 12 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Kenna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Montgomery

Bozeman (Rural)

100 days

Page

U. S. Naval Hospital

1933 S. Tenth Street

Ray

Harold

Collins

April 7

Canadian

September 17, 1918

Foreign Service Office

Government

London

USA

Her. J. Collins

Albion Morrow

Hospital Records

U. S. Navy

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April 7

7:30 PM

December 22, 1917

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Vern H. Hunt 1001 1001

U. S. Naval Hospital, Bethesda, Md.

Original

Doc. E. B. B. B.

Washington, D. C.

U. S. Naval Hospital, Bethesda, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04689

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE FLORIDA b. COUNTY DADE ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIAMI 48X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11807-PITSON ROAD		d. STREET ADDRESS 657- S.W. 11th ST	
3. NAME OF DECEASED (Type or print) First ABRAHAM Middle I. Last COHEN		4. DATE OF DEATH Month APRIL Day 26 Year 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR-24-1898
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHYSICIAN (RET.)		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) N.Y. CITY
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME MORRIS COHEN	
14. MOTHER'S MAIDEN NAME SARAH SILVERSTEIN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address S.S.P. MD. 12028 CLARIDGE B.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.01 DUE TO Coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 20 years DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 15, 1961 to April 26, 1962 that I last saw the deceased alive on April 26, 1962 , and that death occurred at 2 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John J. Curry M.D.		ADDRESS (Street, city or town, state) 10620 Georgetown Silver Spring	
PHYSICIAN'S NAME (Type)		DATE SIGNED 4/26/62	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	22b. DATE THEREOF 4/27/62	22c. NAME OF CEMETERY OR CREMATORY KIRSCHENBAUM BROS.	22d. LOCATION (City, town, or county) (State) BROOKLYN, N.Y.
23. FUNERAL DIRECTOR'S SIGNATURE Bellevue Funeral Home		ADDRESS 4217-9th ST NW	
24a. REC'D BY REGISTRAR APR 30 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: All this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04691

CERTIFICATE OF DEATH

04690

Item 23 Film G311 4/23/62 mh

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 32 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Woodland Beach		d. STREET ADDRESS 02X-2	
3. NAME OF DECEASED (Type or print) William Thomas Conway		4. DATE OF DEATH Month April 11,		Day 1962		Year 1962		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 29, 1884		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 02		IF UNDER 24 HRS. Days 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Service Man		10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY USA							
13. FATHER'S NAME Joseph Conway		14. MOTHER'S MAIDEN NAME Mary Murray		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombosis in distribution of right middle cerebral artery (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 month											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)											
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that XX (this hospital) attended the deceased from March 9, 1962 to April 11, 1962 that (X) (we) last saw the deceased alive on April 11, 1962 , and that death occurred at 2:55 AM on the causes and on the date stated above.													
22a. SIGNATURE John R. Warmolts MD		22b. DATE SIGNED XX April 11, 1963		22c. PHYSICIAN'S NAME (Type) JOHN R. WARMOLTS LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 14, 1962		23c. NAME OF CEMETERY OR CREMATORY New St. Mary's Cemetery		23d. LOCATION (City, town or county) Bellmawr, New Jersey							
24. FUNERAL DIRECTOR'S SIGNATURE Benjamin Hopping		24a. REC'D BY REGISTRAR APR 16 '62		24b. REGISTRAR'S SIGNATURE Charles L. Hopper									

04030

04030

U. S. Naval Hospital
Bethesda (Main)
32 days
Conway
April 11, 1961

Joseph Conway
Bethesda Marine Man
Pennsylvania
USA
April 11, 1961
U. S. Naval Hospital
Bethesda (Main)
32 days
Conway
April 11, 1961

JOHN R. WRIGHT LT NO 01
U. S. Naval Hospital, Bethesda, MD
April 11, 1961
April 11, 1961
April 11, 1961

U. S. Naval Hospital, Bethesda, MD
April 11, 1961
April 11, 1961
April 11, 1961

04692

CERTIFICATE OF DEATH

04691

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA (RURAL) c. LENGTH OF STAY IN 1b 27 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. NAVAL HOSPITAL, BETHESDA, MD.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE VIRGINIA b. COUNTY ARLINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 5626 5th ST. S. ARLINGTON d. STREET ADDRESS 83X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) Virginia Dellinger COPE		4. DATE OF DEATH Month Day Year APRIL 26 1962		5. SEX Female		6. COLOR OR RACE Cauc.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-16-87		9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -----				11. BIRTHPLACE (County & State, or foreign country) MINN.				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Daniel N. DETLINGER				14. MOTHER'S MAIDEN NAME Clara C. HELFRICH				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. Unknown				17. INFORMANT (D) Consuelo Cope TAYLOR Same as #2 above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of Breast 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonic Heart Disease, with Aortic Insufficiency 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)															
20c. TIME OF INJURY Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3-31 , 1962, to 4-26 , 1962, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4-26 , 1962, and that death occurred at 9:35 AM the causes and on the date stated above.																			
22a. SIGNATURE P.G. LINAWEAVER 1CDR MC USN 22b. DATE SIGNED 4-26-62																			
22c. PHYSICIAN'S NAME (Type or print) P.G. LINAWEAVER				22d. ADDRESS U.S. NAVAL HOSPITAL, BETHESDA, MARYLAND				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22f. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 4-30-62				23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL				23d. LOCATION (City, town or county) (State) ARLINGTON, VIRGINIA							
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT MURPHY				24a. ADDRESS 3524 COL. PIKE ARLINGTON, VA.				24b. REC'D BY REGISTRAR APR 30 '62				24c. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 should be filed with the funeral director. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

04693

CERTIFICATE OF DEATH

Reg. Dist. No. 04692

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>57 BETHESDA</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5802 OSCEOLA RD</u>		d. STREET ADDRESS <u>15802 OSCEOLA RD</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>CATHERINE</u> Middle <u>ANN</u> Last <u>COX</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>15</u> Year <u>1962</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-4-1940</u>	
9. AGE (In years last birthday) <u>22</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>EDWARD SUMNER COX</u>		14. MOTHER'S MAIDEN NAME <u>LAURA AGNES SMITH</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		
17. INFORMANT <u>EDWARD S. COX</u>		Address <u>5802 OSCEOLA RD</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 434.1 DUE TO <u>edema of lungs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 mths.</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>May 1944</u> to <u>April 1962</u> , that I last saw the deceased alive on <u>April 1, 1962</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3574 Ave NW</u> DATE SIGNED <u>4/1/62</u> ACTUAL SIGNATURE <u>J. K. Brady</u> M.D. <u>3574 Ave NW</u> PHYSICIAN'S NAME (Type) <u>J. CHESTER BRADY MD</u> <u>3574 Ave NW</u> <u>4-1-62</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>4-4-62</u>		22b. DATE THEREOF		
22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>		22d. LOCATION (City, town, or county) (State) <u>WHEATON, MD.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Remedy Haulon</u> ADDRESS <u>4748 Wisc Ave NW</u>		24a. REC'D BY REGISTRAR DATE <u>APR 9 '62</u>		
24b. REGISTRAR'S SIGNATURE <u>Arthur S. P...</u>				

1881

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES M. JONES		35		Male		White		1881	
PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS	
At home		Dropsy of the lungs		Natural		Pneumonia		Cough, fever, etc.	
RESIDENCE		OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS	
No. 123 St. N. W.		Farmer		High School		Methodist		Married	
FATHER'S NAME		MOTHER'S NAME		BIRTH DATE		BIRTH PLACE		BIRTH TIME	
J. M. Jones		S. M. Jones		1846		Maryland		10:00 AM	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS TOXICITY		PREVIOUS INJURY	
None		None		None		None		None	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK	
J. M. Jones		S. M. Jones		J. M. Jones		S. M. Jones		J. M. Jones	

M

CERTIFICATE OF DEATH

04693

04694

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>21 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>North Carolina</u> b. COUNTY <u>Landis</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>70X-3</u> d. STREET ADDRESS <u>No street address</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Milton Larry Crowder</u>				4. DATE OF DEATH <u>April 20, 1962</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 7, 1940</u>							
9. AGE (In years last birthday) <u>22</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.												
Months	Days												
Hours	Min.												
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Lee A. Crowder</u>									
14. MOTHER'S MAIDEN NAME <u>Amanda Nix</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>No</u>									
16. SOCIAL SECURITY NO. <u>240-56-7542</u>				17. INFORMANT <u>The Medical Record</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intrapulmonary Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Bone Marrow Aplasia</u> DUE TO (c) <u>Chronic myelogenous leukemia</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from March 30, 1962 to April 20, 1962 that (I) (we) last saw the deceased alive on April 20, 1962 and that death occurred at 7:15 A.M. from the causes and on the date stated above. 22a. SIGNATURE <u>Geo. H. Porter III M.D.</u> 22c. PHYSICIAN'S NAME (Type) <u>George H. Porter III, M.D.</u>													
22b. DATE SIGNED <u>April 20, 1962</u> 22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</u>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/23/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WEST LAWN CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>CHINA GROVE NORTH CAROLINA</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers</u>				25a. REC'D BY REGISTRAR <u>APR 24 '62</u>									
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				25c. ADDRESS <u>1400 CHAPIN ST, N.W., WASH DC</u>									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, and 4 may be filed with the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01003

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Lowell, Caroline

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Lowell, Caroline

Lowell, Caroline

Lowell, Caroline

March 30, 1962

April 30, 1962

May 31, 1962

June 30, 1962

July 31, 1962

August 31, 1962

September 30, 1962

04695

MEDICAL CERTIFICATION

<p>1. PLACE OF BIRTH a. COUNTY <u>MONTGOMERY</u> MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BELTUSDA</u></p> <p>c. LENGTH OF STAY IN 1b <u>4 1/2 MOIS.</u></p> <p>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6720-BRIGADOON DR</u></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>NEW YORK</u> b. COUNTY <u>NY</u></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1387-ST NICHOLAS AVE LIX.3</u></p> <p>d. STREET ADDRESS <u>NEW YORK-NY</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>
<p>3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>DAVID</u> Last <u>DAVID</u></p>	
<p>4. DATE OF DEATH Month <u>APR</u> Day <u>20</u> Year <u>1962</u></p>	
<p>5. SEX <u>FEMALE</u></p> <p>6. COLOR OR RACE <u>WHITE</u></p> <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> <p>8. DATE OF BIRTH <u>1894</u></p> <p>9. AGE (In years last birthday) <u>68</u> yrs.</p> <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u></p> <p>10b. KIND OF BUSINESS OR INDUSTRY <u>—</u></p> <p>11. BIRTHPLACE (State or foreign country) <u>ROMANIA</u></p> <p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p> <p>13. FATHER'S NAME <u>ABRAHAM Z-HAIBISH</u></p> <p>14. MOTHER'S MAIDEN NAME <u>SARAH</u></p>	<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u></p> <p>16. SOCIAL SECURITY NO. <u>059109623</u></p> <p>17. INFORMANT <u>ETHEL D. TELCHIN</u> Address <u>6720 BRIGADOON DR</u></p>
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral + Pulmonary Metastases</u> <u>170</u> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma, breast, Right.</u> DUE TO (c) <u>—</u></p> <p>INTERVAL BETWEEN ONSET AND DEATH <u>1-1 1/2</u> <u>6-mos</u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u></p> <p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u></p> <p>20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>—</u> 19 <u>—</u></p> <p>20d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u></p> <p>20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u></p>	
<p>21. I certify that I attended the deceased from <u>December 10, 1961</u>, to <u>April 20, 1962</u>, that I last saw the deceased alive on <u>April 19, 1962</u>, and that death occurred at <u>3:00</u> M., from the causes and on the date stated above.</p> <p>ADDRESS (Street, city or town, state) <u>1712 Eye St. NW.</u> DATE SIGNED <u>—</u></p> <p>ACTUAL SIGNATURE <u>Stanley J. Talpers</u> M.D. <u>—</u></p> <p>PHYSICIAN'S NAME (Type) <u>STANLEY J. TALPERS M.D. Washington 6 D.C.</u></p>	
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u></p> <p>22b. DATE THEREOF <u>APRIL 22, 1962</u></p> <p>22c. NAME OF CEMETERY OR CREMATORY <u>MT HEBRON CEMETERY</u></p> <p>22d. LOCATION (City, town, or county) (State) <u>FLUSHING L.I. N.Y.</u></p>	
<p>23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Bauspirtz</u> ADDRESS <u>3501-14th NW.</u></p> <p>24a. REC'D BY REGISTRAR <u>APR 23 1962</u> DATE <u>—</u></p> <p>24b. REGISTRAR'S SIGNATURE <u>—</u></p>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be released by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B

Blank certificate form with horizontal lines for text entry.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-61

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
04695															
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN b. 3 1/2 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Balls Nursing Home 7420 Maple Avenue				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE -- b. COUNTY -- c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS 6001 North Dakota Ave., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) AMANDA ELIZABETH DAVIS				4. DATE OF DEATH April 11 1962				5. SEX female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME William Lewis				14. MOTHER'S MAIDEN NAME Jane Sarah Lewis				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no			
17. INFORMANT George H. Davis				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 442X DUE TO Cardio vascular Renal Disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Semility. Infirmities of age				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 1 wk.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from Oct 4-11-62 to 4-11-62 and that death occurred at 7:28 PM from the causes and on the date stated above.				22a. SIGNATURE James Hawfield M.D.			
22b. DATE SIGNED				22c. PHYSICIAN'S NAME (Type) JAMES HAWFIELD				22d. ADDRESS 1150 Conn. Ave NW Washington				22e. SIGNATURE			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4/14/1962				23c. NAME OF CEMETERY OR CREMATORY Fairfax Cemetery				23d. LOCATION (City, town or county) (State) Fairfax, Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				24a. ADDRESS 2901 14th St. N.W. Washington 9, D.C.				25a. REC'D BY REGISTRAR APR 13 '62				25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

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VS. A15ME
5M 9/60

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
04696

1. PLACE OF DEATH COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland b. COUNTY Montgomery	
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring 21	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium + Hosp.		d. STREET ADDRESS 10319 Crestmoor Dr.	
3. NAME OF DECEASED (Type or print) Nellie (NMN) DEAKIN		4. DATE OF DEATH 4 6 1962	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-4-06
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY MARMELSTEIN		14. MOTHER'S MAIDEN NAME Frieda ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420-1			
DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of previous heart disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschaw		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BROSCAW		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Apr 6 1962	
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APRIL 8, 1962	
22c. NAME OF CEMETERY OR CREMATORY BETH SHOLOM CEMETERY		22d. LOCATION (City, town, or country) (State) HILLSIDE Md.	
23. FUNERAL DIRECTOR B. Danzansky + Sons		ADDRESS 3501 - 14th St NW	
24a. REC'D BY REGISTRAR APR 13 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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FOR STATE
HEALTH DEPT
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TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
04698		Item 13 Film 0311		4/25/62 mb		04697			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mnty</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY in 1b <u>4 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>35 Silver Spring</u>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>12329 Charles Rd</u>					e. STREET ADDRESS <u>12329 Charles Rd</u>				
3. NAME OF DECEASED (Type or print) <u>Mary Columbia Dement</u>					4. DATE OF DEATH <u>Apr. 17 1962</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-23-1890</u>		9. AGE (In years last birthday) <u>72</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Anna M. Herold</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Jas. Dement</u> Address <u>Stuen 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.O.A. about 10 yrs ago</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>4-17-62</u>									
ACTUAL SIGNATURE <u>Frank J. Bloschert</u>		EXAMINER'S NAME (Type) <u>FRANK J. Bloschert</u>		Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/20/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>		22d. LOCATION (City, town, or country) (State) <u>SUITLAND, MARYLAND</u>			
23. FUNERAL DIRECTOR <u>James T. Ryan, Inc.</u> ADDRESS <u>317 Pa. Ave., S.E.</u>				24a. REC'D BY REGISTRAR <u>APR 23 '62</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Charles S. Harris</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be marked "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/6D

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04699

04698

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>37 Silver Spring</u>		d. STREET ADDRESS <u>2606 Elnora St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Bailey</u> Last <u>DeWitt</u>				4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/7/15</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auditor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>York Air Cond.</u>		11. BIRTHPLACE (State or foreign country) <u>Alabama</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Thos. B. DeWitt, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Abma V. Halsey</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>Navy</u>	
16. SOCIAL SECURITY NO. <u>578-05-5216</u>		17. INFORMANT <u>Brother, William DeWitt</u>		Address <u>Beth., Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial Infarct</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Insufficiency</u> DUE TO (c) <u>Coronary arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4201</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Was driver of car which struck tree</u>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Street</u>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bethesda</u>		20d. (City or town) (County) (State) <u>Mont. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D.		DATE SIGNED <u>April 17, 1962</u>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		Address (Street, city, town, or county) <u>Arlington, Virginia</u>		22a. REC'D BY REGISTRAR <u>APR 18 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/19/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Maryland</u>		24a. DATE <u>APR 18 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

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Report of the Secretary of the Department of the Interior
for the year ending June 30, 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed in by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04700

04699

Items 8 & 9 Film G312 5/7/62 iwk

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN b. 42 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Silver Spring d. STREET ADDRESS 500 Gilmore Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last Dominick Anthony DI CICCIO SR				4. DATE OF DEATH Month Day Year April 30 19 62									
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 4, 1901		9. AGE (In years last birthday) 60 64 yrs.		IF UNDER 1 YEAR Months Days 60 64		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Officer				10b. KIND OF BUSINESS OR INDUSTRY Illinois				12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Unknown DI CICCIO				14. MOTHER'S MAIDEN NAME Unknown									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES				16. SOCIAL SECURITY NO. 578 38 0195		17. INFORMANT Hospital Records		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) Myocardial infarction arteriosclerotic heart disease										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) March 18, 1962 to April 30, 1962		(County)		(State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 18, 1962 to April 30, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 30, 1962 , and that death occurred at 9:55 PM from the causes and on the date stated above.													
22a. SIGNATURE P. G. LINAWEAVER M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> May 1, 1962				22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) P. G. LINAWEAVER LCDR MC USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-4-62		23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION (City, town or county) Arlington, Virginia					
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers				25a. REC'D BY REGISTRAR DATE MAY 3 '62				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

M

U. S. Naval Hospital

Branch (1001)

NO. 1001

UNIVERSITY

Branch

NO. 1001

UNIVERSITY

Naval Officer

UNIVERSITY

UNIVERSITY

UNIVERSITY

Hospital Room

NO. 1001

UNIVERSITY

[Handwritten signature]

March 10, 1941

March 10, 1941

U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled out. The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04701

CERTIFICATE OF DEATH

Reg. Dist. No.

04700

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Philadelphia</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1012 Quebec Terrace</u>		d. STREET ADDRESS <u>3818 N. Ninth St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Elizabeth</u> Last <u>Donnelly</u>		4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>Sep.</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 6, 1916</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael McNamee</u>		14. MOTHER'S MAIDEN NAME <u>Devine, Anna</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>165-14-3950</u>	
17. INFORMANT <u>Daughter - Ann Warren</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>20 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple Sclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 6</u> , 1962, to <u>April 3</u> , 1962, that I last saw the deceased alive on <u>April 3</u> , 1962, and that death occurred at <u>10:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Claire A. Christman</u>		ADDRESS (Street, city or town, state) <u>9703 Riggs Rd.</u>	
PHYSICIAN'S NAME (Type) <u>Claire A. Christman, M.D.</u>		DATE SIGNED <u>4/3/62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 7, 1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Const. Hocken</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Whitall</u>		ADDRESS <u>3603 14th St. NW</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 6 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>	

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH _____	
NAME OF DECEASED _____		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
AGE _____		RACE _____	
PLACE OF BIRTH _____		PLACE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
DATE OF BIRTH _____		TIME OF DEATH _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF REGISTRAR _____	
DATE OF SIGNATURE _____		DATE OF SIGNATURE _____	



RECEIVED

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND VITAL RECORDS ACT OF 1903, AS AMENDED BY THE ACT OF 1910, 1911, 1912, 1913, 1914, 1915, 1916, 1917, 1918, 1919, 1920, 1921, 1922, 1923, 1924, 1925, 1926, 1927, 1928, 1929, 1930, 1931, 1932, 1933, 1934, 1935, 1936, 1937, 1938, 1939, 1940, 1941, 1942, 1943, 1944, 1945, 1946, 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7328 Piney Branch Road</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>187328 - Piney Branch Road -</u> d. STREET ADDRESS <u>1 Takoma Park - Md</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Fred</u> Middle <u>C.</u> Last <u>Duehring</u>		4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1962</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 26, 1884</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Watch Maker</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>			
13. FATHER'S NAME <u>Carl Duehring</u>		14. MOTHER'S M maiden NAME <u>Anna Fischer</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>579-46-0880</u>		17. INFORMANT Address <u>George C. Duehring 104 Parkside Rd SSM</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arterio Sclerosis</u> (a), stating the underlying cause last. } DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>10/11</u> to <u>4/1</u> 19 <u>62</u> that (I) (<u>we</u>) last saw the deceased alive on <u>4/1</u> 19 <u>62</u> and that death occurred at <u>5:30 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>A. B. Little</u>		22b. DATE SIGNED <u> </u>		22c. PHYSICIAN'S NAME (Type) <u>A. B. LITTLE MD</u>			
22d. ADDRESS <u>6911 5th St. NW Washington DC</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 4, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>			
23d. LOCATION (City, town or county) <u>Washington</u>		(State) <u>D.C.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Haller</u>		ADDRESS <u>254 Carroll St NW D.C.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 5 '62</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>							

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MEDICAL CERTIFICATION

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 4 may be detached for use as the burial-transit permit. Then please remove carbon paper, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04703
04702

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c. LENGTH OF STAY IN 1b 11da. 194as. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium and Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Accomack c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Greenbackville d. STREET ADDRESS General Delivery e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Wise Last Dunton		4. DATE OF DEATH Month April Day 21 Year 1962	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26, 1901
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 6 Days 1	IF UNDER 24 HRS. Hours 1 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed		10b. KIND OF BUSINESS OR INDUSTRY Carpenter	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Oswald W. Dunton		14. MOTHER'S MAIDEN NAME Ida E. Taylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) -		16. SOCIAL SECURITY NO. 076-07-9171	
17. INFORMANT Hospital Record		Address Hospital Record	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420 (b) 1 (c) 1 DUE TO 1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Allen Romic Leukemia		INTERVAL BETWEEN ONSET AND DEATH Three Days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from February , 1962, to April 21 , 1962, that (I) (we) last saw the deceased alive on April 22 , 1962, and that death occurred at 6:25 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE Stuart L. Nelson M.D.		22b. DATE SIGNED 4-21-62	
22c. PHYSICIAN'S NAME (Type) STUART L. NELSON		22d. ADDRESS 7600 Carolee Ave Takoma Park, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-24-1962	
23c. NAME OF CEMETERY OR CREMATORY NELSON CEMETERY		23d. LOCATION (City, town or county) (State) Rural-Pocomoke City, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert H. Watson		24b. ADDRESS Pocomoke City, Md.	
25a. REC'D BY REGISTRAR APR 26 '62		25b. REGISTRAR'S SIGNATURE Charles S. Hanna	

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bp

02103

02103

CERTIFICATE OF DEATH

On 11-11-1911 at 10:00 AM

STUART L. NELSON

1500 - 1500

1500 - 1500

1500 - 1500

1500 - 1500

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

04704		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		04703	
04704		CERTIFICATE OF DEATH		Reg. Dist. No. 04703	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>23</u> years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9101 Providence Avenue</u>		d. STREET ADDRESS <u>9101 Providence Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Waters DURING</u>		4. DATE OF DEATH Month Day Year <u>April 2 1962</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 29, 1868</u>	9. AGE (In years last birthday) <u>93</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Post Office (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>John T. DURING</u>		14. MOTHER'S MAIDEN NAME <u>Sorise Peeler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. C. J. Norman</u> Address <u>(Daughter) 9101 Providence Ave Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure (Sudden)</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of prostate</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>1955</u> to <u>April 2, 1962</u> that I last saw the deceased alive on <u>March 31, 1962</u> , and that death occurred at <u>11 A.</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Marion Bankhead</u> M.D.		ADDRESS (Street, city or town, state) <u>9241 Col. Blvd.</u>		DATE SIGNED <u>4/2/62</u>	
PHYSICIAN'S NAME (Type) <u>J. Marion Bankhead</u>		<u>Silver Spring Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-5-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Peace Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Philadelphia Phila, Co, Pennsylvania</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Warner</u>		ADDRESS <u>434 Georgia Ave</u>		24a. REC'D BY REGISTRAR <u>APR 5 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Warner E. Pumphrey, Inc. Silver Spring, Maryland</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04705
04704

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Boyd's</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Rachel</u> Middle <u>V.</u> Last <u>Edwards</u>		4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/22/96</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edgar Van Sickler</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Ball</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Husband, Webster Edwards same</u>	
17. INFORMANT <u>same</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Secondarily Infected Rt. Hip, recent fracture</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>November 1954</u> to <u>12 Apr</u> , 1962, that (I) (we) last saw the deceased alive on <u>11 Apr</u> , 1962, and that death occurred at <u>1255</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Gordon M. Smith</u>		22b. DATE SIGNED <u>12 April 62</u>	
22c. PHYSICIAN'S NAME (Type) <u>GORDON M. SMITH</u>		22d. ADDRESS <u>Barnesville</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/14/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Leesburg Virginia</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>William C. Heltzer, Barnesville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 17 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

20580

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

04706

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04705

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 21 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8210 Cedar Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Crawford Last Ellis		4. DATE OF DEATH Month April Day 19 Year 19 62	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1904
9. AGE (In years lost birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photo engraver		10b. KIND OF BUSINESS OR INDUSTRY Wash. Post Newspaper	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Ellis		14. MOTHER'S MAIDEN NAME Alice Bergen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 578-09-6562	
17. INFORMANT Mrs. Lois Elliott Ellis		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis, Acute 420.1 DUE TO Chronic Coronary Arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) with Angina Pectoris DUE TO Chronic Myocarditis with Cardiac (c) Failure		INTERVAL BETWEEN ONSET AND DEATH 1 hr Undetermined Undetermined	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arterio-sclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1, 1949 to Apr 19, 1962 that (I) (we) last saw the deceased alive on Apr 19, 1962 and that death occurred at 6:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE George L. Ball		22b. DATE SIGNED Apr 19, 1962	
22c. PHYSICIAN'S NAME (Type) George L. Ball		22d. ADDRESS 1630 Georgia Ave Silver Spring Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-23-62	
23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore Baltimore Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR DATE APR 23 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

01302

01302

CENTINATTA DEATH

(M)

George L. Ball
J. L. Ball

12-10-1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04707

04706

1. PLACE OF DEATH e. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park d. STREET ADDRESS 7329 Carroll Avenue a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles (None) Fenwick First Middle Last		4. DATE OF DEATH April 7, 1962 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1894 yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer - retired		10b. KIND OF BUSINESS OR INDUSTRY Printing office	
11. BIRTHPLACE (County & State, or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Fenwick		14. MOTHER'S MAIDEN NAME Agnes Stevens	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service) None		16. SOCIAL SECURITY NO. 213-38-2507 Unavailable	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Cardiac arrhythmia DUE TO Diffuse Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Multiple Myeloma DUE TO Multiple Myeloma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) None	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 2, 1962 to April 7, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 7, 1962 , and that death occurred at 12:53AM from the causes and on the date stated above.			
22a. SIGNATURE John C. Marsh M.D.		22b. DATE SIGNED 4/7/62	
22c. PHYSICIAN'S NAME (Type) John C. Marsh, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1962	23c. NAME OF CEMETERY OR CREMATORY Tue April 10 Congressional Cemetery	23d. LOCATION (City, town or county) S.E. Washington, D.C. (State)
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Zisk WARNER E. PUMPHREY, INC. 8434 Ga. Ave., Silver Spring Md.		25a. REC'D BY REGISTRAR DATE APR 11 '62	
25b. REGISTRAR'S SIGNATURE Charles S. Thomas			

04707

01708

Longevity

Endurance

2 days

James Earl

The Clinical Center, Bethesda, Md.

1959 Carroll Avenue

Thames (London)

Thames

April 7

July 15, 1954

Wife

British Police

London

London - Police

Charles Farnick

James Stewart

The Medical Record

The Clinical Center, Bethesda, Md.

James

62

April 7

April 2

12:30 PM

April 7

Wife

The Clinical Center, National Institutes

of Health, Bethesda, Md.

John A. Lacey, M.D.

The American Psychological Association

Washington, D.C.

AMERICAN PSYCHOLOGICAL ASSOCIATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
04708 Item 9 Film G311 4/18/62 iwk											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)				c. LENGTH OF STAY IN 1b 20 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				d. STREET ADDRESS 4714 Chelsea Lane	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital						a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Theresa Middle Sylinda Last GARDNER			4. DATE OF DEATH Month APRIL Day 8 Year 19 62								
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-24-83		9. AGE (In years last birthday) 78 79 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Harry Boyer						14. MOTHER'S MAIDEN NAME Sylinda BRIGHT					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) - - - - -				16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT Hospital Records				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 420.1 DUE TO Acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Fracture Rt hip (b) Fracture Rt hip (c) Fracture Rt hip										INTERVAL BETWEEN ONSET AND DEATH 10 hrs 19 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) Natural causes				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient was 19 days post op insertion of hip prosthesis, and convalescing well; developed acute M.I.							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. April 19 62		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) Bethesda		(County) Montg.		(State) Md.	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 19 62 to April 8 62 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 8 62 , and that death occurred at 3:12 PM on the causes and on the date stated above.											
22a. SIGNATURE Leo V. Willett						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED April 8, 1962			
22c. PHYSICIAN'S NAME (Type) LEO V. WILLETT LCDR MCUSN						22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-11-62		23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION (City, town or county) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey						ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR APR 12 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Harris	

01208

Monterey

Harborside, (Rural)

30 days

Detonada

U.S. Naval Hospital

U.S. Naval Hospital

Thomas

Florida

CAHNER

AFRIT

Remojo Junction

X

2-24-83

W

Honolulu

Washington, D.C.

USA

Harry Hoyer

Cylinde SECHT

Hospital records

Johnston, W. Johnston

Johnston, W. Johnston

April 8

March 19

April 8

7

ED V. WHITE RESEARCH

U. S. Naval Hospital, Hawaii, HI.

4-11-83

Washington National

Washington, Virginia

Johnston, W. Johnston

W

CERTIFICATE OF DEATH

04 DIVISION

04208

Item 2Film **CERTIFICATE OF DEATH**
infor. for 6/2 Item 3, 100-4-313 5/25/62.cac
birth cer. iwk 2. USUAL RESIDENCE (Where decedent

1. PLACE OF BIRTH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN b 1 day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE MARYLAND b. COUNTY George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights d. STREET ADDRESS 109 Iroquois Way e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Shari Baby Lynne GASCHE		4. DATE OF DEATH Month Day Year APRIL 28 1962	
5. SEX Female		6. COLOR OR RACE Caucasian	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 27 APRIL 1962	
9. AGE (in years last birthday) 1		10. IF UNDER 1 YEAR Months Days 1	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. IF UNDER 24 HRS. Hours Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Montgomery Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Russell GASCHE		14. MOTHER'S MAIDEN NAME Elaine C. GASCHE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Heart Disease 754.5 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 11 hours			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. DEATH WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from 27 APRIL , 19 62 , to 28 APRIL , 19 62 that he (we) last saw the deceased alive on 28 APRIL , 19 62 , and that death occurred at 7 A.M. from the causes and on the date stated above.			
22a. SIGNATURE M. C. O'Bannon M.D.		22b. DATE SIGNED 28 APRIL 1962	
22c. PHYSICIAN'S NAME (Type) M.C. O'BANNON, LT MC USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-1-62	
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY		23d. LOCATION (City, town or county) (State) ARLINGTON, VIRGINIA	
24. SIGNATURE OF REGISTRAR Robert A. Pumphrey		25a. REC'D BY REGISTRAR MAY 1 '62	
24. ADDRESS 7557 Wisc. Ave., Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Krause	

2-055102

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be completed by the hospital or attending physician.

VR A15 (4)
15M 7/61

(M)

Postcard (front)

U.S. Naval Hospital

James Russell Gassett

Removal of Gallbladder

27 April 1962

APRIL

1

USA

Montgomery Maryland

James Russell Gassett

Removal of Gallbladder

Constitutional Heart Disease

11 March

27 April

29 April 1962

U.S. Naval Hospital, Bethesda, Md.

RECEIVED NATION L. GARY, WASHINGTON, VIRGINIA

Robert J. Gassett, 1234 Wisc. Ave., Bethesda, Md.

01710

M

Notary Public

Silver Spring

2 weeks

Notary Public, Silver Spring, Md.

Edward

Notary Public

Notary Public

Notary Public

Notary Public, Silver Spring, Md.

Notary Public

Notary Public

Notary Public

Notary Public

Notary Public, Silver Spring, Md.

Notary Public, Silver Spring, Md.

Notary Public, Silver Spring, Md.

Notary Public

Notary Public

Notary Public, Silver Spring, Md.

Notary Public, Silver Spring, Md.

Notary Public, Silver Spring, Md.

Notary Public, Silver Spring, Md.

Notary Public, Silver Spring, Md.

Notary Public, Silver Spring, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completed and filed in by the funeral director. After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

75

I

2

1

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
04711													
04710													
1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma PARK, MD</u>						c. LENGTH OF STAY IN 1b <u>3/14/62 to 4/4/62</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON SANITARIUM & HOSPITAL</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>422 Mansfield Rd., 24</u>							
d. STREET ADDRESS <u>SILVER SPRING MD</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>GERTRUDE LEE GESSFORD</u>						4. DATE OF DEATH Month Day Year <u>4 4 1962</u>							
5. SEX <u>FE</u>		6. COLOR OR RACE <u>WH</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/17/89</u>		9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Am U.S.A.</u>			
13. FATHER'S NAME <u>George W. Redman</u>						14. MOTHER'S MARRIAGE NAME <u>TREVINIA - SEGER - Segar</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>None</u>						17. INFORMANT Address <u>Stuart Gessford 207 E. Melbourne Ave., Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malegumy, undifferentiated, left</u> <u>197.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>leap lung - pleural effusion</u> DUE TO (c) <u>congestive failure</u>												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Secondary anemia</u>												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> to <u>4 April 1962</u> , that (I) (we) last saw the deceased alive on <u>4 April 1962</u> , and that death occurred at <u>4:42</u> P.M. from the causes and on the date stated above.													
22a. SIGNATURE <u>Ernest E. Harmon</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-4-62</u>					
22c. PHYSICIAN'S NAME (Type) <u>Ernest E. Harmon</u>						22d. ADDRESS <u>9301 Colesville Rd, Silver Spring, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-7-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Zisch</u> <u>Warner E. Pumphrey, Inc. Silver Spring, Maryland</u>						25a. REC'D BY REGISTRAR <u>APR 6 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>					

CERTIFICATE OF DEATH

047112

04711

Items 4 & 23b, Film 0312 5/10/62

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Virginia b. COUNTY Staunton			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Staunton			
c. LENGTH OF STAY in 1b 7 days				d. STREET ADDRESS 1011 Baylor Street			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Henry Doyle GIBSON				4. DATE OF DEATH Month Day Year April 27 1962			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1932	9. AGE (In years last birthday) 29 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Marine Corps			10b. KIND OF BUSINESS OR INDUSTRY - - - - -	11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Luther Gibson			14. MOTHER'S MAIDEN NAME Jannie Robertson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. 6-50 - 11-53 228 42 1217		17. INFORMANT Hospital Records		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Hodgkins Disease 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)			INTERVAL BETWEEN ONSET AND DEATH 8 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 20, 1962 to April 27, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 27, 1962 , and that death occurred 10:10AM from the causes and on the date stated above.							
22a. SIGNATURE Vernon M. Houk, Jr. M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4-27-62		
22c. PHYSICIAN'S NAME (Type) V. N. HOUK, LCDR MC USN			22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 1, 1962	23c. NAME OF CEMETERY OR CREMATORY Augusta Memorial Park		23d. LOCATION (City, town or county) (State) Fishersville, Virginia		
24. FUNERAL DIRECTOR'S SIGNATURE Arnold F. Bunner			ADDRESS Hamrick & Co. Inc., 18 W. Frederick St., -Staunton		25a. REC'D BY REGISTRAR MAY 3 '62	25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Arnold F. Bunner

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U. S. Marine Corps

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FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04719

04712

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>Rt 2 Stewart Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>Donald Emerson Golladay</u>		4. DATE OF DEATH Month <u>4</u> Day <u>22</u> Year <u>1962</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month <u>7</u> Day <u>20</u> Year <u>1944</u>		9. AGE (In years last birthday) <u>18</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Navy</u>				11. BIRTHPLACE (State or foreign country) <u>D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>James Emerson</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Newman</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WWII Navy 26 yrs.</u>				16. SOCIAL SECURITY NO. <u>578-03-4631</u>				17. INFORMANT <u>Mrs. Evelyn Golladay - wife</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of severe heart disease</u>																			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.																			
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Hour <u>0</u> e.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
CHIEF MEDICAL EXAMINER <input type="checkbox"/>																			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>4-22-62</u>																			
Address (Street, city, town, or county)																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4-26-62</u>				22c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>				22d. LOCATION (City, town, or country) (State) <u>Falls Church Fairfax Co., Virginia</u>							
23. FUNERAL DIRECTOR <u>Raymond A. Ziska</u> ADDRESS <u>8434 Georgia Ave</u>																			
24a. REC'D BY REGISTRAR <u>APR 27 '62</u> 24b. REGISTRAR'S SIGNATURE <u>Charles E. Kuntz</u>																			

(N)

M. I. W. 1907

USA

James E. McGowan

James E. McGowan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04714

04713

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>54 Chevy Chase</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>14407 Ridge St.</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>A.</u> Last <u>Goodwin</u>				4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>1962</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/18/87</u>	
9. Age (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>74</u> Days <u>74</u>		IF UNDER 24 HRS. Hours <u>74</u> Min. <u>74</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired (Plasterer)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John T. Goodwin</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Sullivan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give year or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>Myra L. Goodwin</u>				Address <u>13900 15 Ave. B</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>RESPIRATORY FAILURE</u> <u>150X</u> DUE TO <u>CACHEXIA; BRONCHIECTASIS; EMPHYSEMA</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>CARCINOMA OF ESOPHAGUS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>4 DAYS</u> <u>1 YEAR</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 17, 1961</u> to <u>APRIL 30, 1962</u> that (I) (we) last saw the deceased alive on <u>APRIL 29, 1962</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.							
22e. SIGNATURE <u>Joseph D. Connor</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>May 62</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH D. CONNOR, M.D.</u>				22d. ADDRESS <u>9420 Old Georgetown Rd Bethesda 14, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/4/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				ADDRESS <u>Robert A. Pumphrey, Bethesda, Maryland</u>		25e. REC'D BY REGISTRAR <u>MAY 4 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>							

04113

04113

(M)

(A)

For the purpose of this investigation, the following information was obtained from the records of the Bureau of the Census, Washington, D.C., on the subject of the above named individual, who was born on 11/18/21 at [illegible] and is now residing at [illegible]. The individual is a male white, and is a native born citizen of the United States. The individual is currently residing at [illegible] and is employed as [illegible]. The individual is currently residing at [illegible] and is employed as [illegible].

Robert A. Humphrey, Bethesda, Maryland
Arlington Cemetery, Arlington, Virginia
2/5/62

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician and completed and signed in by the funeral director. After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers on pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD b. COUNTY MONTGOMERY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SUBURBAN HOSP.		d. STREET ADDRESS 2107 Hildarose Street	
3. NAME OF DECEASED (Type or print) ESTELLE F. GOTT		4. DATE OF DEATH 4-22-1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-9-90
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) Gethysburg PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FROMMEYER, FRANCIS		14. MOTHER'S MAIDEN NAME KIME, SARAH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-42-9003	
17. INFORMANT John S. Gott (son)		Address 2107 Hildarose St. S.S., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Congestive Heart Failure DUE TO (b) Cardiac Fibullation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Hypertensive Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 4 days 5 days 20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1950 to 22 Apr 1962 , that (I) (the) last saw the deceased alive on 21 Apr 1962 , and that death occurred at 5:05 PM , from the causes and on the date stated above.			
22a. SIGNATURE Merton L. White		22b. DATE SIGNED 22 Apr 62	
22c. PHYSICIAN'S NAME (Type) Merton L. White		22d. ADDRESS 11134 Georgia Ave Silver Spring Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-25-62	
23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		23d. LOCATION (City, town or county) (State) Forest Glen, Montgomery Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Zisk		25a. REC'D BY REGISTRAR APR 26 '62	
25b. REGISTRAR'S SIGNATURE Warner E. Pumphrey, Inc.		25c. REGISTRAR'S SIGNATURE Warner E. Pumphrey, Inc.	

10

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04715

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) 2 days c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) New Alexandria 83X-3 d. STREET ADDRESS 703 16th			
3. NAME OF DECEASED (Type or print) Warren Laise Granger			4. DATE OF DEATH Month April Day 19 Year 1962				
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH June 29, 1898		9. AGE (In years last birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Marine Corps Officer			
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Howard Granger			14. MOTHER'S MAIDEN NAME Lillian Laise				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes		16. SOCIAL SECURITY NO. Hospital Records		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO (b) myocardial ischemia Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. arteriosclerotic coronary insufficiency					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 18, 1962 , to April 19, 1962 that (we) last saw the deceased alive on April 19, 1962 , and that death occurred at 10:35 AM from the causes and on the date stated above.							
22a. SIGNATURE Joseph H. Eusterman M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> April 19, 1962		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) JOSEPH H. EUSTERMAN LT MC USNR			22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-24-62		23c. NAME OF CEMETERY OR CREMATORY Arlington National			
24. FUNERAL DIRECTOR'S SIGNATURE Everly Wheatley Funeral Home, Braddock Rd.,		25a. REC'D BY REGISTRAR DATE APR 23 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be detached by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01515

Virginia

For January

1911

June 30, 1911

Pennsylvania

William Taylor

Hospital Records

April 19, 1911

April 19, 1911

April 19, 1911

U. S. Naval Hospital, Bethesda, Md.

Washington, Virginia

Washington National

Washington, Va.

Washington National

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law may be amended by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04717

CERTIFICATE OF DEATH

04716

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 3 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cur-Lu Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 19 Takoma Park d. STREET ADDRESS 805 Kennebec Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLARA Isabelle GREEN First Middle Last		4. DATE OF DEATH APRIL 11 1962 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE CAUC.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 25, 1884 9. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (County & State, or foreign country) New York 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Issac Gary		14. MOTHER'S MAIDEN NAME Caroline Coseo	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) None		16. SOCIAL SECURITY NO. 577 16 3559A 17. INFORMANT Dorothy G. Lockwood Rt 5 - Frederick, Maryland Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 CONGESTIVE HEART FAILURE DUE TO ARTERIOSCLEROTIC HEART DISEASE AND HYPERTENSIVE CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 10 YRS 12 YRS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) NONE			INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that DOCTOR (this hospital) attended the deceased from MAY 1968 to PRESENT , that (I) (we) last saw the deceased alive on APR 11 1962 and that death occurred at 1250M (11325 1st) from the cause and on the date stated above.			
22a. SIGNATURE Robert P. Hughes, Jr. M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 11 APRIL 62
22c. PHYSICIAN'S NAME (Type) Robert P. Hughes, Jr.		22d. ADDRESS WALTER REED GENERAL HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-13-62	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	23d. LOCATION (City, town or county) (State) Arlington, Virginia
24. FUNERAL DIRECTOR'S SIGNATURE Raymond B. Zick Warner E. Pumphrey, Inc., Silver Spring, Maryland		25a. REC'D BY REGISTRAR APR 16 '62	25b. REGISTRAR'S SIGNATURE Arthur S. Hanna

Figure 1. Schematic diagram of the experimental setup.

0110 2 2003

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed and filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04718

04717

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 13 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gaithersburg d. STREET ADDRESS 6 East Diamond Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Addie Marie Griffith		4. DATE OF DEATH April 30 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1893
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James E. King	
14. MOTHER'S MAIDEN NAME Addie Hurley		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Hodgkin's Disease, generalized 201X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____ INTERVAL BETWEEN ONSET AND DEATH 16 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 17, 19, 1962 to April 30, 1962 that 10 (we) last saw the deceased alive on April 30, 1962 , and that death occurred at 4:05 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Geo. H. Porter III M.D. 22c. PHYSICIAN'S NAME (Type) George H. Porter, III, M.D.		22b. ABOVE SIGNED ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> MAY 1, 1962 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-2-62	23c. NAME OF CEMETERY OR CREMATORY Forest Oak	23d. LOCATION (City, town or county) (State) Gaithersburg, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner-Gaithersburg, Md.		25a. REC'D BY REGISTRAR DATE MAY 3 '62	25b. REGISTRAR'S SIGNATURE Arthur S. Kline

VR A15 (4)
15M 7/61

M

Continued

Continued

Continued

Roberts

13 days

at the

The Clinical Center, Bethesda, Md., 6 East Lincoln Avenue

Address

Marble

Ortloff

April 30

65

James E. King

Marble

May 8, 1953

68

Roberts

Home

Marble

U.S.A.

James E. King

Address

The Medical Record

Home

The Clinical Center, Bethesda, Md., Maryland

to the Clinical Center, Bethesda, Md.

is sent

April 30

April 15, 1953

65

The Clinical Center, Bethesda, Md.,
Institute of Health, Bethesda, Md., 10.

George E. King, III

U.S. Department of Health, Education and Welfare

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. A copy of this certificate may be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04719

04718

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY in lb 11 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 67 GAITHERSBURG d. STREET ADDRESS 428 EAST DIAMOND AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FRED HERBERT GRIMM		4. DATE OF DEATH Month Day Year 4 4 19 62	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-23-74
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MAIL CLERK		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME DANIEL GRIMM	
14. MOTHER'S MAIDEN NAME ANN STAUB		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address HOSPITAL RECORDS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLI DUE TO Conditions, if any, which gave rise to immediate cause (b) THROMBOSIS, DEEP SAPHENOUS VEINS (c) PULMONARY INFARCT, BILATERAL, MULTIPLE. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOCLEROTIC HEART DISEASE.		INTERVAL BETWEEN ONSET AND DEATH 2 days One week Estimated 2 days.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-15 6:40P to 4-4 1962 , that (I) (was) last saw the deceased alive on 4-4 1962 , and that death occurred at 4-5-62 M, from the causes and on the date stated above.			
22a. SIGNATURE Jack Schumacher M.D.		22b. DATE SIGNED 4-5-62	
22c. PHYSICIAN'S NAME (Type) JACK SCHUMACHER, M.D.		22d. ADDRESS GAITHERSBURG, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-7-62	23c. NAME OF CEMETERY OR CREMATORY Forest Oak	23d. LOCATION (City, town or county) (State) Gaithersburg, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner, Gaithersburg, Md.		25a. REC'D BY REGISTRAR DATE APR 9 '62	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



04310

04310

ONTARIO, CANADA

11 DAYS

HOSPITAL GENERAL HOSPITAL

DEPT

MALE

RETIRED MAIL CLERK

HANSEL BRINK

HOSPITAL RECORDS

CHIEF CLERK

THOMAS, ODEY JAPANESE WEISS

PROBABLE INFECTION, GILBERT, WHITE.

ANTHROPOMETRIC HEART DISEASE.

JACK SCHMIDT, N.Y.

WINTERBURN, HANLEY

FOR STATE
HEALTH DEPT.

M

VS. A15ME
5M 7/59

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

04720

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04719

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>45 Bethesda</u>			
c. LENGTH OF STAY IN TB <u>3 yrs</u>				d. STREET ADDRESS <u>6311 Tulsa La</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6311 Tulsa La</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Salvatore Joseph Guidi</u>				4. DATE OF DEATH <u>Apr 8 1962</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-1-1889</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>produce clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>							
13. FATHER'S NAME <u>Baldassare Guidi</u>				14. MOTHER'S MAIDEN NAME <u>Sabina Pagni</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>223-07-7300</u>		17. INFORMANT <u>Joseph Guidi (son)</u> Address <u>Item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>4-20-1</u> IMMEDIATE CAUSE (a) <u>Acute Myocardial Insufficiency</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Coronary Arteriosclerosis</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was passenger in car involved in accident</u>			
20c. TIME OF INJURY Month, Day, Year <u>4-7 1962</u> Hour <u>4:45</u> p.m.				20d. INJURY OCCURRED <u>White</u> <input type="checkbox"/> <u>Not White</u> <input checked="" type="checkbox"/> <u>at work</u> <input type="checkbox"/> <u>at work</u> <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>				20f. (City or town) <u>Bethesda</u> (County) <u>Montg</u> (State) <u>md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Apr 8 1962</u>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/10/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		22d. LOCATION (City, town, or country) <u>Silver Spring, Maryland</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>APR 13 '62</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

MEDICAL CERTIFICATION

64720

10-1-1919

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page.]

Salmonella

Salmonella

221-07-7500

Acute Myocardial Insufficiency

Acute

Coronary Thrombosis

Acute

Coronary Atherosclerosis

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page.]

State of New York

Death

Joseph A. Murphy, Bethesda, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04721						04720					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			a. STATE			b. COUNTY		
MONTGOMERY			KENSINGTON			D.C.			✓		
c. LENGTH OF STAY in lb			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
4 mos.			KENSINGTON GARDENS SANITARIUM			WASHINGTON DC			47X-3		
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH			e. IS RESIDENCE ON A FARM?		
First Middle Last						Month Day Year			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
ROBERT Crigler GUNLEY						APRIL 20 1962					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)		IF UNDER 1 YEAR	
M		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Sept. 13, 1881		80 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
RAINGER - US Govt								Virginia		USA	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
John W GULLEY						BETTIE HASSELTINE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT Address			
No						None		JAMES C. ROGERS 4102 Aspen St. CC, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Carcinoma of Cecum											
DUE TO											
Conditions, if any, which gave rise to immediate cause (b)											
(c) DUE TO											
cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (the hospital) attended the deceased from 12-26, 1961 to 4-20, 1962 that (I) (the) last saw the deceased alive on 4-20, 1962, and that death occurred at 11:15 P.M. from the causes and on the date stated above.											
22a. SIGNATURE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
James W. Egan M.D.									4-20-62		
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
James W. Egan						7720 Wisconsin Ave. - Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
Burial		4/24/62		Ft. Lincoln Cemetery		Prince George Co. Md.					
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS						25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Robert A. Pumphrey, Bethesda, Maryland						APR 26 '62		William L. Thoms			

04721

04720

(1)

Continuation of Census

James W. [unclear]

7750W [unclear]

Robertson, [unclear], [unclear], [unclear]

W. W. [unclear]

Lincoln County, Idaho

15710

Corrected copy Film G311 4/26/62 mh

U. S. Naval Hospital

November 9, 1962

Cassidian

Retired Naval Officer

Abraham Perry

Hospital Records

John Oliver

X

March 10, 1962

April 11, 1962

April 18, 1962

U. S. Naval Hospital, Bethesda, Md.

R. E. ...

Abraham Perry

April

...
...
...

04723

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04722

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CONGRESSIONAL MANOR SANITARIUM		d. STREET ADDRESS 4817 36th St. N.W.	
3. NAME OF DECEASED (Type or print) First EDGAR Middle ALBERT Last HALL		4. DATE OF DEATH Month APRIL Day 3 Year 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-29-1873
9. AGE (In years lost birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROFESSOR		10b. KIND OF BUSINESS OR INDUSTRY COLLEGE	11. BIRTHPLACE (State or foreign country) WISCONSIN
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ALBERT HALL	
14. MOTHER'S MAIDEN NAME LOUISE DRAKE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. ---		17. INFORMANT MARIAN HALL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) ---		INTERVAL BETWEEN ONSET AND DEATH ONE MONTH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-13-1961 to 4-3-1962 that (I) (we) lost the deceased alive on 4-2-1962 and that death occurred at 2 a.m. from the causes and on the date stated above.			
22a. SIGNATURE S. G. Anagnos		22b. DATE SIGNED 4-3-62	
22c. PHYSICIAN'S NAME (Type) S. GEORGE ANAGNOS		22d. ADDRESS 1150 CONNECTICUT AVE. N.W.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 4-4-1962	23c. NAME OF CEMETERY OR CREMATORY ---	23d. LOCATION (City, town, or county) (State) Sherrill, Iowa
24. FUNERAL DIRECTOR'S SIGNATURE Joseph G. Anagnos Inc. 1750 Pa. Ave. N.W. Wash. D.C.		25a. REC'D BY REGISTRAR APR 5 1962	25b. REGISTRAR'S SIGNATURE Arthur S. Frame

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1975

CERTIFICATE OF DEATH

1975

(M)

(1)

UNKNOWN

UNKNOWN

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be executed by the Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PL-43-Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04724 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04723

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 CHEVY CHASE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN		d. STREET ADDRESS 1 3608 THORNAPPLE ST.	
3. NAME OF DECEASED (Type or print) NORMAN Brierley HALL		4. DATE OF DEATH APRIL 26 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/1/86
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rear Admiral, Ret.		9b. KIND OF BUSINESS OR INDUSTRY N.S. Coast Guard	
10a. BIRTHPLACE (State or foreign country) N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Hall		14. MOTHER'S MAIDEN NAME Emma Brierley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --	
17. INFORMANT Gladys Hall (wife)		Address Iten 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Thrombosis, Lt. middle cerebral artery 332x DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Cerebral arterio-sclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Hypertensive heart disease - yes			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> el work el work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Brochart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Brochart		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4-26-62	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4/30/62	
22c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		22d. LOCATION (City, town, or country) Brooklyn, New York	
23. FUNERAL DIRECTOR The S.H.Hines Co. 2901 14th St. N.W. Washington 9, D.C.		24a. REC'D BY REGISTRAR APR 30 '62	
24b. REGISTRAR'S SIGNATURE			

UNITED STATES DEPARTMENT OF THE INTERIOR

1973

(M)

(1)

32

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D.C. 20250

CERTIFICATE OF DEATH

04725

Item 23b Film 0311 1/19/62 wh

04724

1. PLACE OF DEATH e. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 18 Takoma Park			
				d. STREET ADDRESS 7611 Mapel Ave. Apt. #203			
3. NAME OF DECEASED (Type or print) First Thomas Middle Henry Last HALL				4. DATE OF DEATH Month April Day 11 Year 1962			
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-17-89	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Washington D.C.	
						12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas M. Hall				14. MOTHER'S MAIDEN NAME Louise Kessel			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT Address Wife: Mrs Rose A. Hall, Same as #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary edema 260X DUE TO (b) Arteriosclerotic Cardiovascular Disease unk. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Diabetes Mellitus unk.							INTERVAL BETWEEN ONSET AND DEATH 30 minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 6 , 19 62 , to April 11, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 11, 1962 , and that death occurred at 6:10 , from the causes and on the date stated above.							
22a. SIGNATURE Daniel J. Stein, LT MC USN				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 11 April 1962	
22c. PHYSICIAN'S NAME (Type) D.I. STEIN, LT MC USN				22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 16, 1962		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE T. Costello Funeral Home				25a. REC'D BY REGISTRAR APR 16 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	
T. COSTELLO FUNERAL HOME, 1722 N. Capitol St. WDC							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04321

04321

Washington

Washington

Thomas M. Hill

Thomas M. Hill

1963

U.S. Naval Hospital

U.S. Naval Hospital

April 11, 1963

April 11, 1963

April 11, 1963

April 11, 1963

15

2-17-83

Case

Notes

USA

Washington, D.C.

Thomas M. Hill

Thomas M. Hill

Mr. : Mr. H. A. Hill, Room 112

Mr. : Mr. H. A. Hill, Room 112

April 11, 1963

01:10

01:10

01:10

April 11, 1963

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

Virginia

Washington

Washington National

Washington

U.S. Naval Hospital, Bethesda, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician and completed and filed in by the funeral director. After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH e. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN 1b 11 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 Silver Spring				d. STREET ADDRESS 8716 Colesville Road	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kensington Gardens Nursing Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Edward Norman Hamilton			First Middle Last			4. DATE OF DEATH April 3 19 62			Month Day Year		
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 6, 1880		9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired carpenter				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Hamilton						14. MOTHER'S MAIDEN NAME Euphemia Work					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No None				16. SOCIAL SECURITY NO. 578-10-9963		17. INFORMANT Amy V. Hamilton 8716 Colesville Rd, Silver Spring, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pulmonary Edema DUE TO 8 hours Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Cor pulmonale DUE TO 3 years (c) Emphysema (pulmonary) 10 years											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) April 3 1962					
21. I certify that (I) (this hospital) attended the deceased from August 1953 to present , that (I) was last saw the deceased alive on April 3 1962 , and that death occurred at 5 A.M. from the causes and on the date stated above.											
22a. SIGNATURE William Lewis M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 4 April '62		
22c. PHYSICIAN'S NAME (Type) William Lewis MD						22d. ADDRESS 1726 M St. NW Wash DC					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-6-62		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery			23d. LOCATION (City, town or county) (State) Prince George's Co, Maryland				
24 FUNERAL DIRECTOR'S SIGNATURE Raymond A. Fick						25a. REC'D BY REGISTRAR APR 6 '62			25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		
Warner E. Pumphrey, Inc. Silver Spring, Maryland											

(M)

(I)

PROPERTY

Washington

11 months

11 months

Washington (active) during year

Ohio (active) during year

United

United

United

United

male

female

United States

United States

United States

United States

United States

United States

United States

United States

United States

James H. Humphrey, Inc. Silver Spring, Maryland
Fort Lincoln Cemetery
Silver Spring, Maryland
James H. Humphrey, Inc.
Silver Spring, Maryland

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the reason in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

04727
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04726

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY in 1b 20A d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium and Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24 Silver Spring d. STREET ADDRESS 1 Parkvalley Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert First Middle Last Ellsworth Harding		4. DATE OF DEATH April 27 1962 Month Day Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 12 1915 yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Station		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Robert Donald Harding		14. MOTHER'S MAIDEN NAME Eliza G. Harding	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes W.W. 2		16. SOCIAL SECURITY NO. 103 Parkvalley Rd.	
17. INFORMANT Wife		Address 103 Parkvalley Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBARACHNOID HEMORRHAGE 900.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) SKULL FRACTURE (c) FALL DOWN A FLIGHT OF STAIRS		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down stairs at home	
20c. TIME OF INJURY Hour a.m. 2:40 p.m. Month, Day, Year 4-27 1962	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Silver Spring monty md
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Buschert		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BUSCHERT		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF May 1-1962	
22c. NAME OF CEMETERY OR CREMATORY Washington National		22d. LOCATION (City, town, or county) (State) Washington Virginia	
23. FUNERAL DIRECTOR Arthur Statters		24a. REC'D BY REGISTRAR APR 30 1962	
ADDRESS 254 Carroll St		24b. REGISTRAR'S SIGNATURE Arthur Statters	

MEDICAL CERTIFICATION



STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04727

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

LENGTH OF STAY IN b

DOA

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring 14

d. STREET ADDRESS

Marlowe Rd

e. IS RESIDENCE ON A FARM?

YES ☒ NO ☐

f. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington Sanitarium Hosp - R 2.

3. NAME OF DECEASED (Type or print)

Chester ST George Haynes

4. DATE OF DEATH

4 26 1962

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED

NEVER MARRIED ☐

8. DATE OF BIRTH

9-8-07-54

9. AGE (In years last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Printer

10b. KIND OF BUSINESS OR INDUSTRY

U.S. Gov.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Louis Haynes

14. MOTHER'S MAIDEN NAME

Margaret Stanger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

Yes 42-46 US Army

16. SOCIAL SECURITY NO.

42-46 US Army

17. INFORMANT

Mrs Mrs Elfrieda Haynes

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

4201

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Coronary occlusion

INTERVAL BETWEEN ONSET AND DEATH

suicide

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Hour a.m.

Month, Day, Year

19

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DATE SIGNED

DEPUTY MEDICAL EXAMINER ☒

4-26-62

Address (Street, city, town, or county)

ACTUAL SIGNATURE

Frank J. Broschert

M.D.

EXAMINER'S NAME (Type)

FRANK J. BROSCHE

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

4-30-62

22c. NAME OF CEMETERY OR CREMATORY

Washington National

22d. LOCATION (City, town, or country)

Washington - Virginia

(State)

23. FUNERAL DIRECTOR

Arthur Walters

23a. ADDRESS

304 Carroll St. NE

23b. ADDRESS

Takoma Park - DC

24a. REC'D BY REGISTRAR

DATE APR 30 '62

24b. REGISTRAR'S SIGNATURE

Arthur S. Kline

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the reason in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

04757

04757

(M)

(M)

1
FOR STATE
HEALTH DEPT.

TO DEP. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u> d. STREET ADDRESS <u>17100 maple Ave</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. & Hosp.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Leland Merrill Hedgcock</u>			4. DATE OF DEATH <u>4 2 1962</u>		
5. SEX <u>M</u>			6. COLOR OR RACE <u>Wh</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>Aug 15 - 01 60</u>		
9. AGE (In years last birthday) <u>60</u> yrs.			10. IF UNDER 1 YEAR Months Days		
11. IF UNDER 24 HRS. Hours Min.			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Govt.</u>		
11. BIRTHPLACE (State or foreign country) <u>Nebraska</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>George G. Hedgcock</u>			14. MOTHER'S MAIDEN NAME <u>Della Merrill</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>no</u>		
17. INFORMANT <u>Mrs. Esther A. Hedgcock</u> Address <u>(Wife)</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u> DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>4-2-62</u>		
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>April 5 - 1962</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>			22d. LOCATION (City, town, or country) (State) <u>Washington DC</u>		
23. FUNERAL DIRECTOR <u>J. Arthur Walters, 254 Carroll St. NW Wash DC</u>			24. REC'D BY REGISTRAR <u>APR 5 '62</u>		
ADDRESS			25. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>		

MEDICAL CERTIFICATION

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02-02

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04720

04729

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanatorium & Hosp.</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Langley Park</u> 1157-2 d. STREET ADDRESS <u>1806 MERRIMACK DRIVE</u>		
3. NAME OF DECEASED (Type or print) <u>MR. Guy Glen Hendershot</u>			4. DATE OF DEATH <u>4 3 1962</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>10-14-16</u>		9. AGE (In years last birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cable Splicer C&P Tel Co</u>			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>			12. CITIZEN OF WHAT COUNTRY? <u>AMER.</u>		
13. FATHER'S NAME <u>William Hendershot</u>			14. MOTHER'S MAIDEN NAME <u>Mary Brady</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u>			16. SOCIAL SECURITY NO. <u>?</u>		
17. INFORMANT <u>Patient's chert</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage & laceration</u> 976x DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>bullet wound in skull (rt)</u> (c) <u>bullet wound in skull (rt)</u> DUE TO cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted bullet wound in rt skull</u>		
20c. TIME OF INJURY Month, Day, Year Hour <u>5:15</u> p.m. <u>4-2 1962</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Langley Pk.</u>		20g. (County) <u>P.G.</u>		20h. (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschatt</u>			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHATT</u>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>			22b. DATE THEREOF <u>4/6/62</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>			22d. LOCATION (City, town, or country) (State) <u>Prince George's County, Md.</u>		
24a. REC'D BY REGISTRAR <u>APR 6 '62</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanes</u>		

(M)

(I)

MEDICAL CERTIFICATION

2

24c. FUNERAL DIRECTOR - Wash. H. Hanes Co. 2901-14th St. N.W. Wash. D.C.

M

Cable & Wireless Co. Ltd.

Patents & Copyrights

04750

04751

Montgomery

Bedford

The Clinical Center, Bethesda, Md.

White (John)

Female

Housewife

Medical Assistant

None

Medical Assistant

Diagnostic Radiology Division

April 6 62

February 20 62 April 6 62

The Clinical Center, National Institutes of Health, Bethesda, Md.

Anne's Bird Center, Syracuse, New York

April - March 4-4-62

ROBERT A. BURBERRY

Bethesda, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased was in the hospital or attending physician's office, the certificate should be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04732

CERTIFICATE OF DEATH

04731

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <i>Md.</i> b. COUNTY <i>Mont.</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>27 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		35			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington Sanitarium & Hospital</i>				d. STREET ADDRESS <i>4103 Ferrara Dr., 1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Gerard August Frans</i> Middle <i>Heystee</i> Last				4. DATE OF DEATH Month <i>4</i> Day <i>16</i> Year <i>1962</i>					
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4-10-21</i>			
9. AGE (In years last birthday) <i>40</i> yrs.		IF UNDER 1 YEAR Months <i>4</i> Days <i>16</i>		IF UNDER 24 HRS. Hours <i>16</i> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Canceller Netherlands Embassy</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Foreign Service</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Netherlands</i>			
12. CITIZEN OF WHAT COUNTRY? <i>Netherlands</i>				13. FATHER'S NAME <i>Gerard A.F. Heystee</i>					
14. MOTHER'S MAIDEN NAME <i>Eugenie Volleman</i>				Mother's first name = <i>Josephine</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i> NONE				16. SOCIAL SECURITY NO. <i>W.S.H. records.</i>					
17. INFORMANT <i>W.S.H. records.</i>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>abscess of lesser sack</i> 541.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>duodenal ulcer</i> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>polycythemia vera</i>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>3/20</i> , 19 <i>62</i> to <i>4/16</i> , 19 <i>62</i> , that (I) (we) last saw the deceased alive on <i>4/15</i> , 19 <i>62</i> , and that death occurred at <i>5 A.M.</i> , from the causes and on the date stated above.									
22a. SIGNATURE <i>Phillip Bloemsma</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>4-16-62</i>			
22c. PHYSICIAN'S NAME (Type) <i>Phillip Bloemsma</i>				22d. ADDRESS <i>5911 16th St., N.W., Washington, D.C.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4-18-62</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Silver Spring, Montgomery Co., Maryland</i>			
24 FUNERAL DIRECTOR'S SIGNATURE <i>Raymond R. Ziska</i>				25a. REC'D BY REGISTRAR <i>Warner E. Pumphrey, Inc., Silver Spring, Maryland</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04733					04732				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY		Montgomery			a. STATE		Maryland		
		MARYLAND			b. COUNTY		Montg.		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY in 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				
Gaithersburg			1 yr		21 SilverSpring				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Rest Haven. Rest Home					1 10102 Pierce Drive				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
First		Middle		Last		Month		Day	
Nattie		Agnes		Hipsley		Apr		10th	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		White				Oct 5th 1876		85 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		IF UNDER 1 YEAR	
House Wife		Home Work		Gaithersburg. Md.		U S A		Months Days Hours Min.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Rufus Phoebe					Mary P. English				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					17. INFORMANT Address				
					Arthur R. Hipsley. SilverSpring. Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Heart Failure									
DUE TO (b) Arteriosclerotic Heart disease									
DUE TO (c) Senility									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour e.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from 1961 to 4/10, 1962, that (I) (we) last saw the deceased alive on 4/9, 1962 and that death occurred at 2 P.M. from the causes and on the date stated above.									
22a. SIGNATURE					22b. DATE SIGNED				
Luciano I. Leal					M.D.				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
Luciano I. Leal					Gaithersburg Md				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		4-14-62		Forest Oak		Gaithersburg. Md.			
24 FUNERAL DIRECTOR'S SIGNATURE					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Ernest C. Gartner. Gaithersburg. Md.					DATE APR 16 '62		Ernest C. Gartner		

03535

03535

Interpretation of the
document is not possible
due to the poor quality of the
copy.

Handwritten notes at the bottom of the page, including the word "Interpretation" and other illegible text.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b 119 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1610 Varnum Place, N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Howard Lee Holmes		4. DATE OF DEATH Month April Day 11 Year 19 62	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 22, 1922
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Manager		10b. KIND OF BUSINESS OR INDUSTRY Sales	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME (First name unknown) Bell		14. MOTHER'S MAIDEN NAME Hattie Coleman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 577-28-2164	
17. INFORMANT The Medical Record		The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus DUE TO Brain Tumor Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO 237X 15 months		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis, Right lower lobe pneumonia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 13, 1961 to April 11, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 11, 1962 , and that death occurred at 4:35 AM from the causes and on the date stated above.			
22a. SIGNATURE Thomas R. Cate M.D.		22b. DATE SIGNED 4/11/62	
22c. PHYSICIAN'S NAME (Type) Thomas R. Cate, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 4-16-1962	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City, town or county) (State) Ft. Myer Va
24. FUNERAL DIRECTOR'S SIGNATURE Krager's Funeral Home, 389 R.I. Ave. N.W.		25a. REC'D BY REGISTRAR APR 16 '62	25b. REGISTRAR'S SIGNATURE Arthur L. Hunt

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Director of National

Department

Washington

1954

Letter

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1010 North Main, St.

The National Center for Mental Health

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U.S.A.

Virginia

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(First name unknown) 1010

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1010 North Main, St.

The National Center for Mental Health

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be returned by the hospital or attending physician and completed and filed in by the funeral director. After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon page 3 and file it with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04735											
04734											
Item 8 Film G311 4/12/62 mh											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kensington Gardens Sanatorium</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince Geo's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>1614-2</u> d. STREET ADDRESS <u>4802 Barrymore Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>KATHARINE B</u> First <u>HORTON</u> Middle Last		4. DATE OF DEATH <u>APRIL 4</u> Month <u>19</u> Day <u>62</u> Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1878</u> 24 March 1878 Last birthday		9. AGE (In years last birthday) <u>84</u> IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>				11. BIRTHPLACE (County & State, or foreign country) <u>CHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry S. Clapp</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Brightman</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>				16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>MARY H. ORRAY</u> Address <u>4802 Barrymore Dr.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Bronchopneumonia</u> <u>332X</u> DUE TO <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>1 Week</u> <u>6 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
22c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>2/28/49</u> to <u>4-4-62</u> , that (I) (we) last saw the deceased alive on <u>4-3-1962</u> and that death occurred at <u>4:00 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Horace H. Custis, Jr.</u> 22c. PHYSICIAN'S NAME (Type) <u>Horace H. Custis, Jr.</u>						M.D. <u>22d. ADDRESS</u> <u>1852 Columbia Road, N. W., Wash. 9, D.C.</u>		22b. DATE SIGNED <u>4-4-62</u>		22e. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>APR 4 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LEES CREMATORY</u>		23d. LOCATION (City, town or county) (State) <u>300 4th ST NE Wash D.C.</u>		25a. REC'D BY REGISTRAR <u>APR 6 '62</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. ...</u> ADDRESS <u>Wash 2, D.C.</u>				25b. REGISTRAR'S SIGNATURE							



James H. Coates Jr.

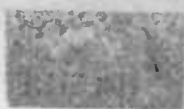
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Md b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring					
c. LENGTH OF STAY IN b. Minutes						d. STREET ADDRESS 13006 Matey Rd					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10209 Douglas Ave						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) John Anthony Howland						4. DATE OF DEATH 4-30 1962					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-26-43		9. AGE (In years last birthday) 19 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Was to enter Univ. of Maryland this term		11. BIRTHPLACE (State or foreign country) Wash D.C		12. CITIZEN OF WHAT COUNTRY? U.S.A		IF UNDER 24 HRS. Hours Min.			
13. FATHER'S NAME John Oswald Howland						14. MOTHER'S MAIDEN NAME Marie Frances LeBuffe					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No						16. SOCIAL SECURITY NO. 577-56-6404		17. INFORMANT John O Howland - Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PENDING Cardiac arrhythmia											
DUE TO 433.1											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Ventricular fibrillation											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Frank J. Busch						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) FRANK J. Busch						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						DATE SIGNED May 1 1962					
22a. BURIAL, CREMATION, REMOVAL (Specify): Burial						22b. DATE THEREOF 5-4-62		22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		22d. LOCATION (City, town, or country) (State) Forest Glen, Montgomery Co., Md.	
23. FUNERAL DIRECTOR Raymond Aziska ADDRESS 8434 Georgia Ave.						24a. REC'D BY REGISTRAR MAY 3 '62		24b. REGISTRAR'S SIGNATURE Charles E. Thomas			
Warner E. Humphrey, Inc., Silver Spring, Maryland						DATE					

MEDICAL CERTIFICATION



(M)

Alfred Henry

Elizabeth

10309 Douglas Ave

John Anthony

Howard

4-30-43

Wash D.C.

John O. Howard

John O. Howard

Washington

1943

Spokane

10309

11th St

4-30-43

Wash D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04737

04736

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN 1b 4 1/2 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9912 Kensington Parkway		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Marya Maryland COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 41 Kensington d. STREET ADDRESS 9912 Kensington Parkway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ira Middle S. Last Hull		4. DATE OF DEATH Month April Day 8 Year 1962	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 13, 1876
9. AGE 86 yrs. IF UNDER 1 YEAR Months 8 Days 8 IF UNDER 24 HRS. Hours 8 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) Elgin, Illinois	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ira L. Sherman	
14. MOTHER'S MAIDEN NAME Fanny Burney		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT Marjorie Hull 9912 Kensington Parkway Address Kensington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Static DUE TO Stasis and debility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Cerebral arteriosclerosis DUE TO Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 week 6 months years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 1, 1961 to April 8, 1962 that (I) (we) last saw the deceased alive on April 7, 1962 and that death occurred at 8:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE John T. Hagenucher M.D.		22b. DATE SIGNED 4-8-62	
22c. PHYSICIAN'S NAME (Type) John T. HAGENBUCHER		22d. ADDRESS 915 19th St., N.W.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-11-62	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington, Virginia		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Zisk Address 8434 Georgia		25a. REC'D BY REGISTRAR DATE APR 11 '62	
25b. REGISTRAR'S SIGNATURE Warner E. Pumphrey, Inc, Silver Spring, Maryland		25c. REGISTRAR'S SIGNATURE Arthur S. Hume	

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FOR STATE HEALTH DEPT.

TO DEATH BY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the death should be reported to the Medical Director, Page 1, and 3 to the Medical Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04738

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04737

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b. <u>9 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington 36</u> d. STREET ADDRESS <u>2707 Calgary Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Amanda</u>	4. DATE OF DEATH <u>4</u> / <u>1</u> / <u>1962</u>	5. SEX <u>F</u>	
6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-8-88-89</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>	
11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Baker</u>		14. MOTHER'S MAIDEN NAME <u>Amanda (unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u> DUE TO <u>9025</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Severe generalized arteriosclerosis</u> DUE TO (c) <u>Fractured left hip</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>Slipped on curb - fracturing left hip</u>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Slipped on curb - fracturing left hip</u>			
20c. TIME OF INJURY Hour <u>1:15</u> p.m. Month, Day, Year <u>3-23-62</u>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Wheaton Plaza</u>	
20e. (City or town) <u>Wheaton</u>		(County) <u>Montgomery</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHEAT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-3-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Rockville Montgomery Co, Maryland</u>	
23. FUNERAL DIRECTOR <u>Raymond A. Ziska</u>		24a. REC'D BY REGISTRAR <u>APR 3 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>		24c. REGISTRAR'S NAME <u>Arthur S. Hanna</u>	

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Victor E. Humphrey, Inc. 2100 York Avenue, Springfield, Mass.

2100 York Avenue, Springfield, Mass.

Springfield, Mass.

Bookings made by the

047739

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

047738

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3801 Conn Ave, Washington DC</u>			
c. LENGTH OF STAY IN 1b <u>21 days</u>				d. STREET ADDRESS <u>47X-3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Resmor Sanatorium + Hospital</u>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Richard</u> Last <u>Hutsell</u>				4. DATE OF DEATH Month <u>4</u> Day <u>28</u> Year <u>1962</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>w</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>83</u> <u>12/18/183</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>28</u>		IF UNDER 24 HRS. Hours <u>12</u> Min. <u>18</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interior Decorator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Tenn</u>		11. BIRTHPLACE (County & State, or foreign country) <u>US</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>William Wythe Hutsell</u>				14. MOTHER'S MAIDEN NAME <u>Martha A. Reagan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>333-03-8293</u>			
17. INFORMANT <u>Mrs. Anna May Hutsell</u>				Address <u>Wash, D.C.</u> <u>3800 Conn. Ave. NW</u>			
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>433.1</u> DUE TO <u>Cerebral Embolus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Arricular fibrillation</u> DUE TO <u>Arteriosclerotic Cardiovascular disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostatic hyper trophy</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>3 months</u> <u>10 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u>19</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-8-1962</u> to <u>4-28-1962</u> , that (I) (we) last saw the deceased alive on <u>4-26-1962</u> , and that death occurred at <u>7:25</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>4-28-62</u>			
22c. PHYSICIAN'S NAME (Type) <u>C. Roger Kottz M.D.</u>				22d. ADDRESS <u>3701 Connecticut Ave. NW Wash DC</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>burial</u>		<u>April 30, 1962</u>		<u>Cedar Hill Cem.</u>		<u>Pr. Geo. Co., Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 30 '62</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death occurs in a hospital, the certificate may be signed by the attending physician and completed by the funeral director. If the death occurs elsewhere, the certificate must be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MEDICAL CERTIFICATION

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Rockville, Md.
Lincoln Park,
Rockville, Md.

4/1/52

Robert A. Brown

Home & Winter 1952

Rockville, Md.
Lincoln Park,
Rockville, Md.
I visited
Lincoln Park,
Rockville, Md.
4/1/52

Rockville, Md.
Lincoln Park,
Rockville, Md.
I visited
Lincoln Park,
Rockville, Md.
4/1/52

TO HOSPITAL, OR TO FUNERAL HOME, OR TO FUNERAL HOME. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completed and in by the funeral director. After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04741

04740

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Krooksville (Rural)</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Krooksville</u> d. STREET ADDRESS <u>Burial</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EXIE</u> Middle <u>KING</u> Last <u>JAMISON</u>		4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 10 1879</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James S. Purdum</u>	
14. MOTHER'S MAIDEN NAME <u>Alice Rebecca Burdette</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>Purdum E. Jamison</u>	
17. INFORMANT <u>Krooksville Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right hemiplegia</u> 334 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) <u>osteoporosis osteoarthritis</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Boys</u>		20g. (County) <u>Md.</u>	
20h. (State) <u>Md.</u>		21. I certify that (I) (this hospital) attended the deceased from <u>MAY 1953</u> to <u>April 4, 1962</u> that (I) (we) last saw the deceased alive on <u>April 3, 1962</u> and that death occurred at <u>M</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>John G. Fawcett</u> M.D.		22b. DATE SIGNED <u>APR 9 '62</u>	
22c. PHYSICIAN'S NAME (Type) <u>John G. Fawcett</u>		22d. ADDRESS <u>Boys Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/7/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bethesda Methodist Browningsville Md.</u>		23d. LOCATION (City, town or county) <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William C. Hilton, Baltimore, Md.</u>		25a. REC'D BY REGISTRAR <u>Arthur L. Kline</u>	
25b. REGISTRAR'S SIGNATURE		25c. DATE <u>APR 9 '62</u>	

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(M)

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John A. Hancock

Boys' M.

TO HOSPITAL OR MORGUE: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the attending physician and completed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04742

04741

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 3913 Morrison St. N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Lewis Wise JENNINGS JR.			4. DATE OF DEATH Month Day Year April 23, 1962		
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 6, 1881	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Officer			10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		
11. BIRTHPLACE (County & State, or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Lewis Wise Jennings Sr.			14. MOTHER'S MAIDEN NAME Nancy Lewis Goodloe		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1905 - 1945			16. SOCIAL SECURITY NO. unk		
17. INFORMANT Mrs. Lucy B. Jennings			Address Same as #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure DUE TO (b) arteriosclerotic heart disease DUE TO (c) antennosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia atrial fibrillation malnutrition					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)		
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 22, 1962 , to April 23, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 23, 1962 , and that death occurred 6:10AM from the causes and on the date stated above.					
22a. SIGNATURE J. H. Eusterman M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE April 23, 62
22c. PHYSICIAN'S NAME (Type) J. H. EUSTERMAN, LT MC USN			22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 26 April 1962	23c. NAME OF CEMETERY OR CREMATORY Arlington, National		23d. LOCATION (City, town or county) (State) Arlington, Virginia
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey			25a. REC'D BY REGISTRAR APR 25 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Hanna

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Continued

Box 100 (Bureau)

1 day

Washington

U. S. Naval Hospital

U. S. Naval Hospital

David

Wife

JENNINGS JR.

U. S. Naval Hospital

Continued

August 6, 1961

80

Naval Officer

U. S. Navy

Virginia

USA

David and Jennings Jr.

Henry David Jennings

1961 - 1962

and

Mrs. Jack P. Jennings, June 20, 1962

April 23, 62

6:10 PM

April 23, 62

J. H. BARNES, JR. MD. 1961

U. S. Naval Hospital, Bethesda, Md.

April 23, 1962

Washington, National

Washington, Virginia

Report of Hospital, 1961, Washington, D.C.

April 23, 1962

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04742

04743

Item 22 Film 0311

4/22/62

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Blue Ridge</u>		c. LENGTH OF STAY IN 1b <u>N.O.A.</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>md</u>		b. COUNTY <u>Montg</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>13 Sandy Spring (rural)</u>		d. STREET ADDRESS <u>1 Dr Bird Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Cimor</u> Middle <u>Johnson</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>Apr</u> Day <u>2</u> Year <u>1962</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-19-1904</u>		9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>		13. FATHER'S NAME <u>Cimor I. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Carie Bellows</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Hosp Record</u> Address <u> </u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUBARACHNOID HEMORRHAGE</u> 700000 } DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>FRACTURE BASE OF SKULL (LEFT)</u> (c) <u>FELL FROM A STAIRS</u>												INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down stair steps at home</u>																			
20c. TIME OF INJURY Hour a.m. <u>3:30</u> p.m. <u> </u> Month, Day, Year <u>4-2 1962</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>				20f. (City or town) <u>Sandy Spring</u> (County) <u>Montg</u> (State) <u>md</u>											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Frank J. Brosch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>4-2-62</u>											
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>				Address (Street, city, town, or county) <u> </u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>April 4, 1962</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial</u>				22d. LOCATION (City, town, or country) <u>Sandy Spring, Md.</u> (State) <u> </u>			
23. FUNERAL DIRECTOR <u>Robert L. Snowden</u>				ADDRESS <u>Rockville, Md.</u>				24a. REC'D BY REGISTRAR <u> </u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>				DATE <u>APR 6 '62</u>							

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

NOV 15 1915

THE STATE
OF NEW YORK

(M)

Sub attached, Herewith
fracture base of skull (left)
fell from a stairs

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04744

04743

Item 23b Film 0311 4/18/62

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb. 10 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton d. STREET ADDRESS 7911 Old Alexandria Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bessie Mae JOHNSON		4. DATE OF DEATH Month April Day 14 Year 1962	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 24, 1919
9. AGE (In years last birthday) 42 yrs.		10. IF UNDER 1 YEAR Months 4 Days 14	11. IF UNDER 24 HRS. Hours 14 Min. 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) , Tenn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clarence Jenkins		14. MOTHER'S MAIDEN NAME Bessie Kate Graham	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. 266-10-4109	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aortic Insufficiency 421.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 4, 1962 , to April 14, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 14, 1962 , and that death occurred at 11:45pm from the causes and on the date stated above.			
22a. SIGNATURE J.J. Ryskamp Jr.		22b. DATE SIGNED April 15, 1962	
22c. PHYSICIAN'S NAME (Type) J.J. RYSKAMP JR.		22d. ADDRESS U. S. Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 16, 1962	23c. NAME OF CEMETERY OR CREMATORY Riverside Memorial Cemetery	23d. LOCATION (City, town or county) (State) Jacksonville, Florida
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		25a. REC'D BY REGISTRAR APR 17 '62	
ADDRESS Bethesda, Md. 7557 Wisc. Ave.		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04718

Business Books

17-1-10

Inventory

CLINTON

11-1-10

Deceased (M.L.)

17-1-10 11-1-10 11-1-10

U. S. Naval Hospital

17-1-10

11-1-10

11-1-10

December 20, 1910

Deceased

Deceased

11-1-10

Deceased

Deceased (M.L.)

Deceased (M.L.)

Deceased (M.L.)

11-1-10

11-1-10

11-1-10

11-1-10

U. S. Naval Hospital, Honolulu, Territory

U. S. Naval Hospital, Honolulu, Territory

11-1-10

11-1-10

11-1-10

TO HOSPITAL OR AFTER DEATH. The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04745

CERTIFICATE OF DEATH

04744

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pleasant View Nursing Home</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown</u>	
c. LENGTH OF STAY in 1b <u>3 wks</u>		d. STREET ADDRESS <u>Pleasant View Nursing Home</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pleasant View Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marshall Edward Johnson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 8, 1890</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, & foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Rosetta - Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mildred Stewart - Germantown - Md</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Degeneration</u> <u>592X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Hypertension</u> DUE TO (c) <u>Nephritis, Chr. Interstitial</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4-6 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u> </u> Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <u>this hospital</u> attended the deceased from <u>2 April</u> , 19 <u>62</u> to <u>23 April</u> , 19 <u>62</u> that (I) <u>two</u> last saw the deceased alive on <u>23 Apr</u> , 19 <u>62</u> and that death occurred at <u>10:54 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>L A Butler</u>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>D. A. Butler</u>		22d. ADDRESS <u>2710 Norbeck Road Rd</u>	
23a. BURIAL, CREMATION, <u>Burial</u> (Specify)	23b. DATE THEREOF <u>4/26/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Asbury.</u>	23d. LOCATION (City, town or county) (State) <u>Germantown, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Suwode</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 1 '62</u>	
ADDRESS <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

232

4

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The following table shows the results of the regression analysis for the dependent variable "Number of children" (N = 1,000). The independent variables are "Age" and "Gender". The table includes the coefficient estimates, standard errors, t-statistics, and p-values for each variable.

Variable	Coefficient	Standard Error	t-statistic	p-value
Age	0.05	0.01	5.00	0.000
Gender	0.10	0.02	5.00	0.000
Constant	1.50	0.10	15.00	0.000

17 0085 3 25

• **Table 2** **Summary of the results of the study**

9 • 17764

• 33 •

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04746

04745

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>1 day + 11 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Silver Spring</u> d. STREET ADDRESS <u>10901 Lombardy Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lise Flora Kasmir</u>		4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1962</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 23, 1946</u>
9. AGE (In years last birthday) <u>16</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	11. BIRTHPLACE (County & State, or foreign country) <u>New York State</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Kasmir</u>	
14. MOTHER'S MAIDEN NAME <u>Babette Ross</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Hospital Record.</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>4 5 2 X</u> DUE TO <u>Cerebral Hemorrhage (Subarachnoid)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Probable ruptured aneurysm</u> (b) <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		21. I certify that (I) (this hospital) attended the deceased from <u>April 22, 1962</u> to <u>April 24, 1962</u> that (I) (we) last saw the deceased alive on <u>April 23, 1962</u> and that death occurred at <u>1 A.M.</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Ralph Stiller</u> M.D.		22b. DATE SIGNED <u>April 24, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ralph Stiller</u>		22d. ADDRESS <u>1110 Spring Street, Sil. Spr.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/26/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ARK. NATL. Cem.</u>		23d. LOCATION (City, town or county) (State) <u>ARK. VA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Deedee Funeral Home</u> ADDRESS <u>4217-9th Ave</u>		25a. REC'D BY REGISTRAR <u> </u> DATE <u>APR 27 '62</u>	
25b. REGISTRAR'S SIGNATURE <u> </u>		25c. REGISTRAR'S SIGNATURE <u> </u>	

(M)

(1)

1946

CERTIFICATE OF DEATH

01815

Student

Charles K. K...

Robert R...

Hospital Room

Charles K. K...

Robert R...

None

x

John J...

Robert R...

John J...
Robert R...

VR A15 (4)
15M 7/61

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01316

1747

M

2-10-50

at your club life

John R. [unclear]

Barney Green has 407-2-2111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be completed by the hospital or attending physician. Part 2 may be completed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY in b 43 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 6918 Decatur Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Timothy John Kearney				4. DATE OF DEATH April 18 1962		5. SEX Male			
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 10, 1904		9. AGE (In years last birthday) 57 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Setter		10b. KIND OF BUSINESS OR INDUSTRY Not known		11. BIRTHPLACE (County, State, or foreign country) Idaho Shelby		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Timothy John Kearney, Sr.				14. MOTHER'S MAIDEN NAME Arvilla Smith					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes 1925 - 1932				16. SOCIAL SECURITY NO. 044-01-0638				17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypotension DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic adenocarcinoma of the kidney DUE TO (c) Azotemia, hypercalcemia, hypercalciuria								INTERVAL BETWEEN ONSET AND DEATH 1 day 13 months 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 6, 1962 to April 18, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 18, 1962 , and that death occurred at 3:00 P.M. , from the causes and on the date stated above.									
22a. SIGNATURE Richard S. Rivlin M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> April 18, 1962				22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Richard S. Rivlin, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/23/62		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington Va.			
24. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home Inc.				25. REC'D BY REGISTRAR APR 24 '62		26. REGISTRAR'S SIGNATURE James A. Hume			

(M)

01217

The following information was obtained from the records of the
Department of Health, London, on the 1st of January, 1952.
The records show that on the 1st of January, 1952, there were
in the Department of Health, London, a total of 1,234 cases
of the disease known as "The Disease".
The records also show that on the 1st of January, 1952, there
were in the Department of Health, London, a total of 1,234 cases
of the disease known as "The Disease".
The records also show that on the 1st of January, 1952, there
were in the Department of Health, London, a total of 1,234 cases
of the disease known as "The Disease".

(1)

The following information was obtained from the records of the
Department of Health, London, on the 1st of January, 1952.
The records show that on the 1st of January, 1952, there were
in the Department of Health, London, a total of 1,234 cases
of the disease known as "The Disease".
The records also show that on the 1st of January, 1952, there
were in the Department of Health, London, a total of 1,234 cases
of the disease known as "The Disease".
The records also show that on the 1st of January, 1952, there
were in the Department of Health, London, a total of 1,234 cases
of the disease known as "The Disease".

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

04749

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04748

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Chevy Chase</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>4611 High Street</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Michael Mardon Kelly</u>				4. DATE OF DEATH Month Day Year <u>April 29 1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 21, 1959</u>	
9. AGE (In years last birthday) <u>2 1/2</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Robert Arnold Kelly</u>				14. MOTHER'S MAIDEN NAME <u>Carolyn Keyser</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT <u>(Carolyn Kelly) mother</u>				Address <u>same as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive intraabdominal hemorrhage</u> DUE TO <u>Rupture, large - liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Auto Accident</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture left fibrous tibia bone</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr</u> <u>1 1/2 hr</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Run over by auto in driveway at home</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>11:50 PM 4-29-1962</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>				20f. (City or town) (County) (State) <u>Chevy Chase Mont Md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Bhosham</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BHOSHAM</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>4-29-62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-2-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR <u>St. Don. DeVol 2224 Wisconsin Wash. DC</u>				24a. REC'D BY REGISTRAR <u>MAY 2 '62</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur D. Smith</u>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04750

CERTIFICATE OF DEATH

04749

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY in 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Mont. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 33 Wheaton d. STREET ADDRESS 13503 Grenoble Dr. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edwin Middle G Last Kerans		4. DATE OF DEATH Month April Day 23 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/10/10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist		11. BIRTHPLACE (County & State, or foreign country) Missouri	
13. FATHER'S NAME Edwin Grattan Kerans		14. MOTHER'S MAIDEN NAME Belle Kitchell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) yes Marines		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT daughter, Mary Ellen Kerans, same as above		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 420 DUE TO coronary atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) myocardial infarction DUE TO coronary atherosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 45 min. 1 hr. 5 yrs?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/1/58 to 4/23/62 , that (I) (we) last saw the deceased alive on 4/23/1962 and that death occurred at 8:30 AM from the causes and on the date stated above.			
22a. SIGNATURE Dr. Stephen Jones M.D.		22b. DATE SIGNED 4/23/62	
22c. PHYSICIAN'S NAME (Type) Dr. Stephen Jones		22d. ADDRESS Rockville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/25/62	
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION (City, town or county) (State) Silver Spring, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Dunphy, Bethesda, Maryland		25a. REC'D BY REGISTRAR APR 26 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Evans			

CERTIFICATE OF DEATH

Item # Film 6312

5/1/62 iwk

04750

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington-Santa Lucia Med Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>MARYLAND</u> f. COUNTY <u>Montgomery</u> g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> h. STREET ADDRESS <u>8206 Roanoke Avenue</u> i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>Earl</u> Middle <u>-</u> Last <u>KERR</u>		4. DATE OF DEATH Month <u>4</u> Day <u>21</u> Year <u>1962</u>		5. SEX <u>Boy</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-2-62</u>		9. AGE (In years last birthday) yrs. <u>12</u>		IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u>		IF UNDER 24 HRS. Hours <u>12</u> Min. <u>12</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery County, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Wendell E. Kerr</u>								14. MOTHER'S MAIDEN NAME <u>Barbara Sue Owens</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>				17. INFORMANT <u>CHART</u> Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.0</u> DUE TO <u>Hyaline membrane disease</u> Conditions, if any, which gave rise to immediate cause (b) <u>atelectasis both lungs</u> (c) <u>atelectasis both lungs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>																INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>4/21</u> to <u>4/21</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>4/21</u> , 19 <u>62</u> , and that death occurred at <u>6:00</u> P.M., from the causes and on the date stated above.																	
22a. SIGNATURE <u>Herbert H. Diamond</u> M.D.								ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>4/22/62</u>					
22c. PHYSICIAN'S NAME (Type) <u>Herbert H. Diamond</u>								22d. ADDRESS <u>911 Silver Springs Ave SE Md</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF <u>4-23-62</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Flacahy</u>				23d. LOCATION (City, town or county) (State) <u>Prince Georges</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walter</u> ADDRESS <u>254 Carroll St - No</u>								25a. REC'D BY REGISTRAR <u>APR 24 '62</u>				25b. REGISTRAR'S SIGNATURE <u>James S. [Signature]</u>					

2-006394

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be detached and filed with the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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4/20/18

4/21/18

Hyphomyscus
testator

Hyphomyscus
testator

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04752
04751

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY in 1b <i>1 day 16 1/2 hrs</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium and Hospital</i>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> d. STREET ADDRESS <i>10800 Georgia Ave. Apt. 1</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>William Roy Kerr</i>		4. DATE OF DEATH Month <i>April</i> Day <i>24</i> Year <i>1962</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1889</i> AGE in years last birthday <i>73</i> IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Printer</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Missouri</i>	
13. FATHER'S NAME <i>James Stanley Kerr</i>		14. MOTHER'S MAIDEN NAME <i>Victoria Sullinger</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>579-38-8731</i>	
17. INFORMANT <i>Ora M. Kerr</i>		18. ADDRESS <i>10,800 Georgia Silver Spring, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>cerebral hemorrhage</i> (c) <i>arterial hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>3 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized arteriosclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>4/22</i> , 19 <i>62</i> to <i>4/24</i> , 19 <i>62</i> that (I) (we) last saw the deceased alive on <i>4/23</i> , 19 <i>62</i> , and that death occurred <i>6:05 A</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Daniel B. Washington</i> M.D.		22b. DATE SIGNED <i>4/24/62</i>	
22c. PHYSICIAN'S NAME (Type) <i>Daniel B. Washington MD</i>		22d. ADDRESS <i>6234 Gd. Ave. N.W. Wash. D.C.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>4-26-62</i>	23c. NAME OF CEMETERY OR CREMATORY <i>National Memorial Park, Inc</i>	23d. LOCATION (City, town or county) (State) <i>Falls Church Fairfax Co., Va.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond Q. Zisk</i> ADDRESS <i>434 Georgia Ave. Silver Spring, Maryland</i>		25a. REC'D BY REGISTRAR DATE <i>APR 27 '62</i>	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04752

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 59 Bethesda			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6701 Wilson Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EDWARD		First W.		Middle KIBBEY		Last	
4. DATE OF DEATH April 12, 1962		Month		Day		Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 13, 1892	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR 11 Months		IF UNDER 24 HRS. 29 Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate		10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Thomas E. Kibbey				14. MOTHER'S MAIDEN NAME Lillian Wefstwich			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 1		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Wife Dorothy C. Kibbey		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Coronary Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Sudden Weeks	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart		EXAMINER'S NAME (Type) FRANK J. BROSCART		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 12, 1962	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/16/62		22c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery		22d. LOCATION (City, town, or country) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR Robert A. Pumphrey, Bethesda, Maryland				24a. REC'D BY REGISTRAR APR 17 1962		24b. REGISTRAR'S SIGNATURE Arthur J. Hines	

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ANNUAL REPORT OF THE
DEPARTMENT OF AGRICULTURE

DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
04755											
04754											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN 1b 19 min. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Gaithersburg Rural Rt. #2 d. STREET ADDRESS Rural Rt. #2 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First BABY BOY Middle KING Last 4. DATE OF DEATH Month 4 Day 9 Year 19 62											
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-9-62		9. AGE (In years last birthday) yrs. 19		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Montgomery, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Willard B King				14. MOTHER'S MAIDEN NAME Agnes Louise Ward							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT hospital records			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 Atelectasis lungs Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Prematurity and Immaturity (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 4/9/62 19 to 4/9/62 19, that (I) (we) last saw the deceased alive on 4/9/62 19, and that death occurred 8:00 P.M. from the causes and on the date stated above.											
22a. SIGNATURE G. F. Meadors 22c. PHYSICIAN'S NAME (Type) G. F. MEADORS, M.D.				M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/10/62			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-11-62		23c. NAME OF CEMETERY OR CREMATORY Church of Brethern Laytonsville, Md.			23d. LOCATION (City, town or county) (State) Redland, Mont. Maryland				
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber				25a. REC'D BY REGISTRAR APR 13 '62		25b. REGISTRAR'S SIGNATURE William J. Hume					

2-052336

STATE OF TEXAS
COUNTY OF DALLAS

1933

JOHN J. O'NEAL
JAN 11 1933

JOHN J. O'NEAL
JAN 11 1933

JOHN J. O'NEAL
JAN 11 1933

82

4-2-32

male white

JOHN J. O'NEAL
JAN 11 1933

none

o e

JOHN J. O'NEAL
JAN 11 1933

hospital records

none

no

*John J. O'Neal
Jan 11 1933*

JOHN J. O'NEAL
JAN 11 1933

JOHN J. O'NEAL
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JOHN J. O'NEAL
JAN 11 1933

JOHN J. O'NEAL
JAN 11 1933

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04756 CERTIFICATE OF DEATH 04755

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase, 51 d. STREET ADDRESS 3616 Taylor Street a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) James Allen King				4. DATE OF DEATH Month April Day 6, Year 19 62							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 28 August 1911		9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail carrier				10b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office		11. BIRTHPLACE (County & State, or foreign country) District of Columbia				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Raymond W. King				14. MOTHER'S MAIDEN NAME Margaret V. Cocker							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No				16. SOCIAL SECURITY NO. 577-20-9950		17. INFORMANT The Medical Record, The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage from recurrent carcinoma of larynx DUE TO 161 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Epidermoid carcinoma of the larynx DUE TO (c) 2 1/2 years INTERVAL BETWEEN ONSET AND DEATH 3 days											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) April 3, 1962 to April 6, 1962		(County) Rockville, Maryland		(State) Maryland	
21. I certify that (H) (this hospital) attended the deceased from April 3, 1962 to April 6, 1962 , that (H) (we) last saw the deceased alive on April 6, 1962 , and that death occurred 12:15 PM from the causes and on the date stated above.											
22a. SIGNATURE Robert H. Wilkins M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 4-6-62			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) Robert H. Wilkins, M.D.						22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/10/62		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery				23d. LOCATION (City, town or county) (State) Rockville, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland						25a. REC'D BY REGISTRAR DATE APR 13 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

1958

OUTLET

between

the financial center, Bethesda, Md.

time

late

and carrier

Raymond A. King

517-10-9920 The District of Columbia, Maryland

Department of the Interior, Bureau of Land Management

with regard to the land

April 3, 1958

April 6, 1958

F. C. H. White

Robert A. Williams, Jr.

the District of Columbia, Maryland
Instituted by Health, Bethesda, Md.

Washington County

Robert A. Ramsey, Bethesda, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be removed by the hospital or attending physician and completely destroyed by the funeral director. After this certificate has been signed by the attending physician and completely destroyed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>2 1/2</u> days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>42 Kensington</u>		d. STREET ADDRESS <u>10612 Wheatley St.,</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Verna</u> Middle <u>L.</u> Last <u>Kipps</u>				4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>19 62</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/15/86</u>		9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Charles M. Ingram</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Montgomery</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				17. INFORMANT Address <u>Charles B Kipps - Son - Anne 2d</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis, left middle cerebral artery</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, cerebral</u> DUE TO (c) <u>Arteriosclerosis general</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>As thymic bronchial emphysema pulmonary</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH 1953</u> to <u>APRIL 16, 1962</u> , that (I) (we) last saw the deceased alive on <u>APRIL 15, 1962</u> , and that death occurred at <u>8:30 A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert G. Angle</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/16/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert G. Angle</u>				22d. ADDRESS <u>Del Ray Avenue, Bethesda, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/18/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>APR 19 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN lb <u>36 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>53 Chevy Chase</u> d. STREET ADDRESS <u>1 29 Quincey St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>IRENE S. KIRKWOOD</u> First Middle Last 4. DATE OF DEATH <u>4 28 1962</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>1/28/84</u> 9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>Morgan Sherwood</u> 14. MOTHER'S MAIDEN NAME <u>Maria Hurdle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> 16. SOCIAL SECURITY NO. <u>-</u> 17. INFORMANT <u>daughter - Jean White</u> Address <u>-</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1 congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1957</u> to <u>27 Apr 1962</u> that (I) (we) last saw the deceased alive on <u>27 Apr 1962</u> and that death occurred at <u>4:15 AM</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Herbert Martyn Jr</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>HERBERT MARTYN JR</u> 22d. ADDRESS <u>4740 Chevy Chase Dr</u> 22b. DATE SIGNED <u>28 Apr 62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4-30-1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Glavin</u> ADDRESS <u>1756 R Ave NW, Wash DC</u> 25a. REC'D BY REGISTRAR <u>MAY 2 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

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Handwritten notes and signatures, including dates like 1/28/84 and 1/29/84, and names like Kirkwood.

Large handwritten signature or name, possibly "Kirkwood".

Handwritten notes at the bottom, including dates like 1/29/84 and 1/30/84, and names like "Kirkwood".

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>1817 Reedie Drive</u>	
3. NAME OF DECEASED (Type or print) <u>MORRIS</u> First <u>KOBAK</u> Middle Last		4. DATE OF DEATH <u>April 22</u> Month Day Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/15/85</u>
9. AGE (In years lost birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Office Mgr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Austria</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Samuel Kobak</u>		14. MOTHER'S MAIDEN NAME <u>Esther Weisner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR COLLAPSE</u> <u>1810</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>POST-OPERATIVE FROM SURGERY</u> DUE TO (c) <u>CARCINOMA OF BLADDER</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>5 days</u> <u>MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/21</u> , 19 <u>60</u> to <u>4/22</u> , 19 <u>62</u> that I last saw the deceased alive on <u>4/21</u> , 19 <u>62</u> , and that death occurred at <u>1230</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1015 SPRING ST, SILVER SPRING, MD</u> DATE SIGNED <u>APR 23 1962</u>			
ACTUAL SIGNATURE <u>Arthur J. Willets</u>		M.D. <u>1015 SPRING ST, SILVER SPRING, MD</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR J. WILETS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/23/62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ind. Heb. Soc. Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Norwalk, Conn.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzansky & Sons</u>		24. REGISTRAR'S SIGNATURE <u>Arthur J. Willets</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, or within 72 hours after death, if the deceased was attending physician and completely filled in the funeral director's certificate. After this certificate has been signed by the attending physician and completely filled in the funeral director's certificate, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1920

(M)

State of New York
County of ...
City of ...
I, the undersigned, being a duly qualified medical officer of health for the City and County of ... do hereby certify that ...
Name of Deceased ...
Age ...
Sex ...
Race ...
Date of Death ...
Place of Death ...
Cause of Death ...
Signature of Medical Officer of Health ...
Signature of Registrar ...
Date of Registration ...

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

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SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04759

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1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Md. c. LENGTH OF STAY IN 1b 6 mos. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5602 Pollard Rd., Bethesda, Md.		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Maryland 57 d. STREET ADDRESS 5602 Pollard Rd., 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Nellie B. Lamb		4. DATE OF DEATH Month Day Year April 14, 1962	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 25, 1887	
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days 74	
11. IF UNDER 24 HRS. Hours Min. 74		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sidney I. Besselievre		14. MOTHER'S MAIDEN NAME Nellie Ecker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Son, Wm. Ers Lamb, Jr. (Same as above)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) 420 DUE TO (c) 420 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While Not While of work of work <input type="checkbox"/> <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 4-14-62 DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
ACTUAL SIGNATURE Frank J. Broschant		EXAMINER'S NAME (Type) FRANK J. Broschant	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 4-16-62	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR APR 19 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

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MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>907 Wesley Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Kern Lambert</u>		4. DATE OF DEATH <u>Apr 20 1962</u>	
5. SEX <u>male</u> 6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>12-2-24</u>		9. AGE (In years last birthday) <u>37</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>grocery</u>	
11. BIRTHPLACE (State or foreign country) <u>Tenn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>	
13. FATHER'S NAME <u>Redford Lambert</u>		14. MOTHER'S MAIDEN NAME <u>May A. Pounce</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>411 20 6223</u>	
17. INFORMANT <u>Janet Lambert (wife)</u>		Address <u>Stur 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, lectory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 23 62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or country) (State) <u>Rockville Md.</u>	
23. FUNERAL DIRECTOR <u>Francis H. Barber</u>		ADDRESS <u>Laytonsville, Md</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 24 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04762

04761

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Florida b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) U. S. Naval Vase, Key West			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				d. STREET ADDRESS 1063 Halsey Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Hamilton Last Langton				4. DATE OF DEATH Month April Day 7 Year 19 62			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1923	9. AGE (In years last birthday) 38 yrs.	IF UNDER 1 YEAR Months 2 Days 4 Hours 3 Min.	IF UNDER 24 HRS. Hours 48 Min. X-3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Officer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Langton				14. MOTHER'S MAIDEN NAME Aldeliade Jones			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Mary Jane Langton		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.4 Alenkenic leukemia. DUE TO Conditions, if any, which gave rise to immediate cause (b) 2 months (c) 2 months DUE TO (e), stating the underlying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 21, 19 62 to April 7, 19 62 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 7 ,.....19 62 , and that death occurred 1:10PM from the causes and on the date stated above.							
22a. SIGNATURE Charles E. Brodine M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Charles E. Brodine, LCDR USN (MC)				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-10-62		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Chambers Funeral Home, 8655 Georgia Ave.				25a. REC'D BY REGISTRAR APR 12 '62		25b. REGISTRAR'S SIGNATURE Arthur L. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR DURING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Person may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04763		CERTIFICATE OF DEATH				04762			
Item 23b, Film G311 4/13/62 iw k									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY in 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 27 Silver Spring d. STREET ADDRESS 1958 Rosemary Hills Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Edward Middle K. Last Lawless					4. DATE OF DEATH Month April Day 4, Year 19 62				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/10/10		9. AGE (In years last birthday) 51 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wage Spec.				10b. KIND OF BUSINESS OR INDUSTRY Govt.		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPH THOMAS LAWLESS					14. MOTHER'S MAIDEN NAME MARIE ANTILOTTI				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 1943-45 225 07 083		17. INFORMANT Miss Theodora Krout, friend			Address same as above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-1 DUE TO CORONARY occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Coronary sclerosis DUE TO (c) Obesity								INTERVAL BETWEEN ONSET AND DEATH 1 hour Several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Feb. 20 , 19 61 , to April 4 , 19 62 ; that (I) (we) last saw the deceased alive on 4/4 , 19 62 , and that death occurred at last M, from the causes and on the date stated above.									
22a. SIGNATURE Max G. Sherer M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/4/62		
22c. PHYSICIAN'S NAME (Type) MAX G. SHERER MD					22d. ADDRESS 2025 EAST West H'way Silver Spring, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/9/1962		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION (City, town or county) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus ADDRESS 3801 N. FAIRFAX DRIVE ARLINGTON 3, VA					25a. REC'D BY REGISTRAR APR 6 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rural</u>		d. STREET ADDRESS <u>East 13th Street</u>	
3. NAME OF DECEASED (Type or print) <u>OLIVIA</u> First Middle Last <u>V LAWSON</u>		4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1962</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct-7-1886</u>
9. AGE (In years lost birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>6</u> Days <u>18</u> Hours <u>—</u> Min. <u>—</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house-wife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11c. BIRTHPLACE (State or foreign country) <u>Montgomery Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Harrison</u>		14. MOTHER'S MAIDEN NAME <u>Cornelia Martha H. Harten</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-34-060</u>	
17. INFORMANT <u>Andrew F. Himes</u>		18. ADDRESS <u>Route 1, Monrovia, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic myocardial degeneration, Refractive</u> (c) <u>Chronic Asthma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec-4-</u> 19 <u>61</u> , to <u>April-25-</u> 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>April-22-1962</u> , and that death occurred at <u>12</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>William C. Miller</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM C. MILLER</u>		22d. ADDRESS <u>7 Brook Ave., Gaithersburg, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burn</u>		23b. DATE THEREOF <u>4-28-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hejalskum Lutheran Ch</u>		23d. LOCATION (City, town, or county) (State) <u>Frederick Co. Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Harten</u>		25a. REC'D BY REGISTRAR <u>APR 30 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Himes</u>			

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TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04765

04764

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>12 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Rheems</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Post Office Box 207</u> d. STREET ADDRESS <u>75X-3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eric Jon Lehman</u>		4. DATE OF DEATH Month Day Year <u>April 23, 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6 April 1955</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania</u>	11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>
13. FATHER'S NAME <u>Curtis Lehman</u>		14. MOTHER'S MAIDEN NAME <u>Janice Weaver</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war/branch of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>The Medical Record</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO (b) <u>Pneumonia</u> DUE TO (c) <u>Cystic Fibrosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>587.3</u> DUE TO (b) <u>Pneumonia</u> DUE TO (c) <u>Cystic Fibrosis</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Months</u> <u>7 Years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>APRIL 11, 1962</u> to <u>April 23, 1962</u> , that (I) (we) last saw the deceased alive on <u>April 23, 1962</u> , and that death occurred at <u>11:25AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Daniel V. Kimberg</u> M.D.		22b. DATE SIGNED <u>4/23/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Daniel V. Kimberg M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4/24/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ELIZABETHTOWN PA.</u>	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE <u>W W Chambers Co., 1400 E. Washington St NW, Washington DC</u>		25a. REC'D BY REGISTRAR <u>APR 25 '62</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>

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1. General Information

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04765

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Wash D.C.</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wash. D.C.</u>	
c. LENGTH OF STAY IN 1b <u>2 1/2 hrs</u>		d. STREET ADDRESS <u>5013 14th St. N.W. Wash, D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. Saw + Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Leibert Joseph Matthias Leibert</u>		4. DATE OF DEATH <u>4 27 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-16-1873</u>
9. AGE (In years last birthday) <u>88 yrs.</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>27</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Potomac Power Co. - Chief Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pa.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Richard W. Leibert</u>		14. MOTHER'S MAIDEN NAME <u>Roberta S. Leibert Maria Krauss</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, (no) or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-05-0821</u>	
17. INFORMANT <u>Records of Wash. Saw + hosp.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) <u>10 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 1954</u> to <u>Apr. 27, 1962</u> , that (I) (we) last saw the deceased alive on <u>Apr. 27, 1962</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John Lawrence Avery</u> M.D.		22b. DATE SIGNED <u>4/27/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>John Lawrence Avery</u>		22d. ADDRESS <u>10110 Georgia Ave. Silver Spring Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/1/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Nisky Hill Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Bethlehem, Pennsylvania</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>WES. H. HINES Co.</u> ADDRESS <u>2901 14th St. N.W. WASHINGTON 9, D.C.</u>		25a. REC'D BY REGISTRAR <u>APR 30 62</u> DATE <u>APR 30 62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

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- Chief Clerk

NORTH TOWN

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John Lawrence Avery
10110 Locust Ave. Silver Spring

John Lawrence Avery

Wally Hill Cemetery, Bethlehem, Pennsylvania

Bureau 5/1/62

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04767

CERTIFICATE OF DEATH

04766

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN b 2½ years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 420 Kerwin Road				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 32 Silver Spring d. STREET ADDRESS 420 Kerwin Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Russell Last Lent		4. DATE OF DEATH Month April Day 24 Year 19 62					
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1892	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Director		10b. KIND OF BUSINESS OR INDUSTRY American Gun Assn.		11. BIRTHPLACE (County & State, or foreign country) New York			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Samuel D. Lent			14. MOTHER'S MAIDEN NAME Mary Lee				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 045-03-6101		17. INFORMANT Address Mrs. Mabel E. Lent 420 Kerwin Rd, S.S., Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchiogenic Carcinoma 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between ONSET and DEATH 1 year					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Feb 11, 1960 to April 24, 1962			
21. I certify that (I) (this hospital) attended the deceased from Feb 11, 1960 to April 24, 1962 that (I) (we) last saw the deceased alive on April 24, 1962 and that death occurred at 9:30 A.M. from the causes and on the date stated above.							
22a. SIGNATURE John J. Curry		22b. DATE SIGNED 4/24/62					
22c. PHYSICIAN'S NAME (Type) John J. Curry		22d. ADDRESS 10,620 Georgia Ave, Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-26-62	23c. NAME OF CEMETERY OR CREMATORY Reformed Dutch Church Cemetery		23d. LOCATION (City, town or county) (State) Montrose Westchester Co., New York			
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR APR 27 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Hines			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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1. **MARYLAND STATE DEPARTMENT OF HEALTH**
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04768		04767	
1. PLACE OF DEATH e. COUNTY Montgomery f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda g. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE New Jersey b. COUNTY Hudson c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Jersey City d. STREET ADDRESS 608 Palisade Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Concetta Mary Letizia		4. DATE OF DEATH Month April Day 28 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 17, 1938
9. AGE (In years last birthday) 24 yrs.		10. IF UNDER 1 YEAR Months 2 Days 11 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME John Letizia		14. MOTHER'S MAIDEN NAME Bessie Ruvalo	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 151-30-5163	
17. INFORMANT The Medical Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Cardiac failure 754.5 DUE TO Cardiac surgery of pulmonic valvulotomy & closure of atrial septal defect Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last: Cyanotic congenital heart disease (Pulmonic stenosis and atrial septal defect)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH 12 hours 19 hours birth	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Hour e.m. Month, Day, Year 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 10 (this hospital) attended the deceased from March 27, 1962 to April 28, 1962 , that we last saw the deceased alive on April 28, 1962 , and that death occurred at 5:40AM from the causes and on the date stated above.			
22a. SIGNATURE James L. Talbert M.D.		22b. DATE SIGNED 4/28/62	
22c. PHYSICIAN'S NAME (Type) James L. Talbert, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 4-28-62		23b. DATE THEREOF 4-28-62	
23c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery		23d. LOCATION (City, town or county) (State) Bergen County, New Jersey	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR MAY 4 '62	
ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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James A. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. If the deceased was retained by the hospital or attending physician, the certificate should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04769 CERTIFICATE OF DEATH 04768

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Mont. Co.</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Be the 302</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>11 Rockville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban</i>		d. STREET ADDRESS <i>917 Crawford Drive</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Carrie Burns Lytton</i>		4. DATE OF DEATH Month Day Year <i>April 14 1962</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 25, 1889</i>
9. AGE (In years last birthday) <i>72</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired national government</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Zachariah Taylor</i>		14. MOTHER'S MAIDEN NAME <i>thebecca Vermillion</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year of entry and date of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>214-12-726</i>	
17. INFORMANT <i>Balfour Lytton</i>		Address <i>53rd Ave Above</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive retroperitoneal hemorrhage</i> 451X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <i>Ruptured aneurysm of abdominal aorta</i> DUE TO (c) <i>Atherosclerosis severe of, aorta</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i> <i>1 hr</i> <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>Pul. TBC.</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>4/1/62</i> to <i>4/14/62</i> , that (I) (we) last saw the deceased alive on <i>4/13/62</i> and that death occurred at <i>3:00 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Stephen V. Jones</i>		22b. DATE SIGNED <i>4/15/62</i>	
22c. PHYSICIAN'S NAME (Type) <i>Stephen V. Jones</i>		22d. ADDRESS <i>Rockville, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4/17/62</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn</i>		23d. LOCATION (City, town or county) (State) <i>Rockville, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Tyson Wheeler</i>		25. REC'D BY REGISTRAR DATE <i>APR 18 '62</i>	
ADDRESS <i>Funeral Home-1351 E. Montgomery Ave. Rockville, Maryland</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	

(M)

(2)

Montgomery
to the
Tubman
Carrie
made white
Virginia
214-15-204
U.S.A.
James
April 14 1912

Massive retroperitoneal hematoma
Required amputation of abdominal wall
Anastomosis done at 2 ports

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04770

04769

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San & Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 16 md.</u> d. STREET ADDRESS <u>9406 Sierra St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Christopher Magee</u>		4. DATE OF DEATH <u>4 - 5 1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-16-92</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auditor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Drug Store</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Christopher Magee</u>		14. MOTHER'S MAIDEN NAME <u>Annie O'Bray</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>105P</u>	
17. INFORMANT <u>Arthur L. Kline</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Left PAROTITIS & septicemia</u> 177X DUE TO <u>Post-op. prostatectomy</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>Adenocarcinoma of prostate</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>6 "</u> <u>?</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>no</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/28 1962</u> to <u>4/5 1962</u> that (I) (we) last saw the deceased alive on <u>4/5 1962</u> and that death occurred at <u>105P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph Bloom</u> M.D.		22b. DATE SIGNED <u>4/6/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph Bloom, M.D.</u>		22d. ADDRESS <u>800 1015 Spring Silver Spring Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-9-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Bladensburg, Maryland</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Real Funeral Home, Wash D.C.</u>		25a. REC'D BY REGISTRAR <u>APR 11 '62</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

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TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. It is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MONTGOMERY												MARYLAND											
1. PLACE OF DEATH a. COUNTY Montgomery												2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE _____ b. COUNTY _____											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring												c. LENGTH OF STAY IN 1b 4 days											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7701 Eastern Avenue Apt. #201												c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47X-3											
d. STREET ADDRESS 3150 16th St., N.W.												e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Lelia Sophie Manning												4. DATE OF DEATH Month Day Year April 26 19 62											
5. SEX female												6. COLOR OR RACE white											
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>												8. DATE OF BIRTH March 20, 1908											
9. AGE (In years last birthday) 54 yrs.												10. IF UNDER 1 YEAR Months Days Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales clerk												10b. KIND OF BUSINESS OR INDUSTRY shoe store											
11. BIRTHPLACE (County & State, or foreign country) Virginia												12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME Robert L. Annadale												14. MOTHER'S MAIDEN NAME Jerusha Nash											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No None												16. SOCIAL SECURITY NO. 577-05-7904											
17. INFORMANT Lelia Ann Tankersley												Address Linthicum Hgts., Md., 560 Fairmont Rd.,											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) Acute Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH unknown												PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHO PNEUMONIA											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m. 19												20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)												20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 4/24/62 to 4/26/62 that (I) (we) last saw the deceased alive on 4/26/62 8 A.M. and that death occurred at 4 P.M. from the causes and on the date stated above.												22a. SIGNATURE Arthur A. Davis M.D.											
22b. PHYSICIAN'S NAME (Type) ARTHUR A. DAVIS												22c. ADDRESS 8200-16th St. SE 26 Eye St NW											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial												23b. DATE THEREOF 4-30-62											
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery												23d. LOCATION (City, town or county) (State) Prince George's Co., Maryland											
24. FUNERAL DIRECTOR'S SIGNATURE Raymond C. Zisk												25a. REC'D BY REGISTRAR APR 30 '62											
25b. REGISTRAR'S SIGNATURE Warner E. Pumphrey, Inc., Silver Spring, Maryland												25c. REGISTRAR'S SIGNATURE Arthur S. Kraus											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04772

04771

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY in 1b I.O.A d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 5615 Southwick Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SYDNEY MARKS		4. DATE OF DEATH April 13, 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 12, 1918
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Watch Company	11. BIRTHPLACE (County & State, or foreign country) Penna.
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Harry Marks	
14. MOTHER'S MAIDEN NAME Katie Epstein		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II	
16. SOCIAL SECURITY NO. 134-09-9889		17. INFORMANT Wife Ann R. Marks Address Same as Item #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro-intestinal hemorrhage 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Thrombocytopenia (c) Acute leukemia (lymphoblastic)		INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 3 WKS. 4 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 10, 1962 to April 13, 1962 that (I) (we) last saw the deceased alive on April 10, 1962 , and that death occurred at 11:45 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Arnold A. Lear M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 4-14-62	
22c. PHYSICIAN'S NAME (Type) ARNOLD A. LEAR		22d. ADDRESS 1302 18th St. N.W. Washington, D.C.	
22b. DATE SIGNED		22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/17/62	23c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery
23d. LOCATION (City, town or county) (State) Arlington, Virginia		23e. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR APR 19 1962	
25b. REGISTRAR'S SIGNATURE Arthur E. Hanna		25c. REGISTRAR'S SIGNATURE	

1937

1937

Montgomery
 Bethesda
 Maryland
 Bethesda

3015 Southwick Street
 Bethesda Hospital

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

MEDICAL CERTIFICATION

MONTGOMERY COUNTY, MARYLAND											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b <u>1657.2</u>											
2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>MRS. FRIEDA ELIZABETH MAYERHOFER</u> 4. DATE OF DEATH <u>4 2 1962</u>											
5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>12-19-1891</u> 9. AGE (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> 11. BIRTHPLACE (State or foreign country) <u>Germany</u> 12. CITIZEN OF WHAT COUNTRY? <u>Am</u>											
13. FATHER'S NAME <u>August Saglitz</u> 14. MOTHER'S MAIDEN NAME <u>SELMA URBAN</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>PATIENT'S CHART</u> Address											
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>CARDIAC ARREST</u> DUE TO <u>561.4</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Died suddenly following surgery for repair of hiatal hernia</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. DATE SIGNED <u>Apr 3 1962</u>											
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u> Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>4/6/62</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u> 22d. LOCATION (City, town, or country) (State) <u>Southland Md</u>											
23. FUNERAL DIRECTOR <u>W.W. Chambers Co., 8655 Lee Ave., Silver Spring Md.</u> 24a. REC'D BY REGISTRAR <u>APR 5 '62</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thayer</u>											

NO. 10-10-10-10

~~SECRET~~

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04775						04774					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <u>Mont. County</u> <u>MARYLAND</u>						a. STATE <u>Maryland</u> b. COUNTY <u>Mont. P.G.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney, Md.</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville, Md.</u>					
c. LENGTH OF STAY IN 1b <u>6 days</u>						d. STREET ADDRESS <u>1351 Langley Way</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SHARON Building</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Howard F. Mayhew</u>						4. DATE OF DEATH <u>April 3</u> 19 <u>62</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-5-1885</u>		9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Eng.</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Eng.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Vineyard Haven Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Washburn Mayhew</u>						14. MOTHER'S MAIDEN NAME <u>Clara Flanders</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Clara M. Mayhew</u> Address <u>W. Hyattsville, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u>											
334x DUE TO (b) <u>Generalized arteriosclerosis</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Diffuse pulmonary emphysema bilateral</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 28</u> 19 <u>57</u> to <u>April 3</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>March 29</u> 19 <u>62</u> , and that death occurred at <u>1:41</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Aaron H. Traum</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>April 3, 1962</u>		
22c. PHYSICIAN'S NAME (Type) <u>Aaron H. Traum, M. D.</u>						22d. ADDRESS <u>8237 Georgia Ave. Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
<u>Burial</u>		<u>4-5-62</u>		<u>Fort Lincoln Cemetery</u>		<u>Prince George's Co. Maryland</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond J. Warner E. Pumphrey, Inc.</u>						25a. REC'D BY REGISTRAR <u>APR 6 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Traut</u>			

2850

872.53

52-9172-1

D. D. Thompson, Jr.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04776

04775

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Colorado b. COUNTY Aurora (c/o Antoinette Gardner)			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 45 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				e. STREET ADDRESS 1148 Newark Street			
3. NAME OF DECEASED (Type or print) John Francis McCabe				4. DATE OF DEATH Month April Day 4 Year 19 62			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 19, 1906	
9. AGE (In years last birthday) 56		IF UNDER 1 YEAR Months 56 Days 56 Hours 56 Min. 56		IF UNDER 24 HRS. Months 56 Days 56 Hours 56 Min. 56			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreign Service Officer				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (County & State, or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Francis McCabe				14. MOTHER'S MAIDEN NAME Ellen Calvey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown				16. SOCIAL SECURITY NO. - - - -		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia 356.1 DUE TO amyotrophic lateral sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) amyotrophic lateral sclerosis (c) amyotrophic lateral sclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 6 month						INTERVAL BETWEEN ONSET AND DEATH 5 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 21, 1962 to April 4, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 4, 1962 , and that death occurred at 9:55 PM from the causes and on the date stated above.							
22a. SIGNATURE Bartholomew T. Hogan M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED April 5, 1962	
22c. PHYSICIAN'S NAME (Type) BARTHOLOMEW T. HOGAN LT MC USN U. S. Naval Hospital, Bethesda, Md.				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-9-62		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				25a. REC'D BY REGISTRAR APR 6 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

01778

01778

CERTIFICATE OF DEATH

Montgomery

Colorado

et alia (et al)

5 days

et alia

(et alia) (et alia)

U. S. Naval Hospital

U. S. Naval Hospital

John

John

John

John

John

John

John

John

February 19, 1900

Foreign Service Officer, U. S. Government

Foreign Service Officer, U. S. Government

Foreign Service Officer, U. S. Government

Foreign Service Officer, U. S. Government

John Francis McCord

John Francis McCord

Unknown

Unknown

John Francis McCord

John Francis McCord

X

Top. 21, 1900

April 2, 1900

Bartholomew, Jr. known to me as U. S. Naval Hospital, Baltimore, Md.

Washington, D. C.

Washington, D. C.

Washington, D. C.

Washington, D. C.

Washington, D. C.

Washington, D. C.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04776											
1. PLACE OF DEATH a. COUNTY		Item 2 Film G313 5/16/62		1/18/62 mh		USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		a. STATE		b. COUNTY					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		5 yrs		Md		Montg					
10890 Bethesda Church Rd				02 Bethesda		Damascus					
10890 Bethesda Church Rd				10890 Bethesda Ch. Rd							
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Selwyn Otis				McCoy		McCoy		Apr 11 1962			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH		9. AGE (In years last birth day)		IF UNDER 1 YEAR	
male		white		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		3-4-1919		43 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Engineer		duftman		Md		U.S.A					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
Otis Ellis McCoy		Hortense Hermann									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		217-05-1186		Dorothy McCoy (wife)		Itur 2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion											
DUE TO											
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO											
4-20-1											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour e.m. p.m. 19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				DATE SIGNED			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER				4-11-62			
FRANK J. Broschert				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country)		(State)	
Burial				April 4, 1962		Woodlawn		Baltimore, Md.			
23. FUNERAL DIRECTOR				ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Oliver L. Wolcott				Damascus, Md.		APR 13 '62		Charles S. Kraus			

NO. 100
M

DATE

1977

1000

1000-1000

1000-1000

1000-1000

CERTIFICATE OF DEATH

04778

04777

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>3 1/4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington, D.C.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>47X-3</u> d. STREET ADDRESS <u>3317 - 16th St., N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Grace (N MN) McLaurine</u> First Middle Last				4. DATE OF DEATH <u>April 19 1962</u> Month Day Year											
5. SEX <u>female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/4/1885</u>		9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Schools</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Florida</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>George W. McLaurine</u>				14. MOTHER'S MAIDEN NAME <u>Malissa Eliza Frayser</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>Hospital Chart.</u>			
17. INFORMANT <u>Hospital Chart.</u>												18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Splenic (?) hemorrhage</u> <u>204.1</u> DUE TO <u>Low platelets</u> Conditions, if any, which gave rise to immediate cause (b) <u>Subacute Myelogenous Leukemia</u> (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4/19/62</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>4-16-1962</u> to <u>4-19-1962</u> that (I) (we) last saw the deceased alive on <u>4-18-1962</u> and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.															
22a. SIGNATURE <u>Chas H Voloshin</u>												22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Chas H Voloshin</u>												22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				23b. DATE THEREOF <u>4/23/62</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. S. H. Thines</u>												25a. REC'D BY REGISTRAR <u>APR 23 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thines</u>	

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director.



00738

RECEIVED

1947

D.C.

3/1/88

D.C. Schools

Teacher

Rock Creek Cemetery

Washington

1937

1937

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04779

04778

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>6 1/2 hrs.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GAITHERSBURG</u> d. STREET ADDRESS <u>Route # 3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SUBURBAN</u> First Middle Last <u>MAITE</u>		4. DATE OF DEATH <u>APRIL 25 1962</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input checked="" type="checkbox"/> <u>T.</u> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/4/85</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Retired</u>		14. MOTHER'S MAIDEN NAME <u>ARA THRIFT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>4201</u>	
17. INFORMANT <u>DAUGHTER (Mrs. Helen Wells)</u> Address <u>Gaithersburg, Md</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>MYOCARDIAL INFARCTION</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>8 hours</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour e.m. <u>19</u> p.m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>MAY 1950</u>		20g. (County) <u>APRIL 25 1962</u>	
20h. (State) <u>1962</u>		21. I certify that (I) (this hospital) attended the deceased from <u>APRIL 25 1962</u> to <u>APRIL 25 1962</u> that (I) (we) last saw the deceased alive on <u>APRIL 25 1962</u> and that death occurred at <u>6:15 PM</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>John Fawcett</u>		22b. DATE SIGNED <u>APR 27 '62</u>	
22c. PHYSICIAN'S NAME (Type) <u>John Fawcett</u>		22d. ADDRESS <u>1331 West Montgomery</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/27/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Darnestown</u>		23d. LOCATION (City, town or county) (State) <u>Darnestown, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u>		25. REC'D BY REGISTRAR <u>APR 27 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25c. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, pages 1 and 4 may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04780									
04779									
Item 23b Film G311 1/19/62									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Falls Church c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 83x-3 d. STREET ADDRESS 7826 Allen Sturges Terrace e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Jeane Anne MILLER			4. DATE OF DEATH Month April Day 15 Year 19 62						
5. SEX Female		6. COLOR OR RACE Caucasion		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 February 1920		9. AGE (In years last birthday) 42 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Hall County, Nebraska		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Oscar Viereggs				14. MOTHER'S MAIDEN NAME Eva Brass					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A splenification 175-0 DUE TO Wide spread Metastases - Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO AdenoCarcinoma of The Ovary (b) 18 mos (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8 Mar 62 to 15 Apr 62 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 15 1962 , and that death occurred at 2310 pm on the causes and on the date stated above.									
22a. SIGNATURE L.E. Potvin				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) L.E. POTVIN				22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burrial		23b. DATE THEREOF April 21, 1962		23c. NAME OF CEMETERY OR CREMATORY Grand Island Cemetery		23d. LOCATION (City, town or county) (State) Grand Island, Nebraska			
24 FUNERAL DIRECTOR'S SIGNATURE Everly-Wheatley Funeral Home				25a. REC'D BY REGISTRAR APR 17 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

04778

04780

U.S. Naval Hospital
Bethesda (Main)

John

Franklin

Homeville

Conner Village

Home

Home

Home

Home

Home

Home

Home

Home

Home

Home

Home

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be signed by the attending physician and completely filled out by the funeral director, or by the funeral director only. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04780

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Wash.D.C. b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2 wks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
3. NAME OF DECEASED (Type or print) CHALMERS First EASTON Middle MILLS Last		4. DATE OF DEATH April 1st, 19 62 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22nd, 1905
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sign Painter (Retired)		11b. KIND OF BUSINESS OR INDUSTRY Commercial	
11c. BIRTHPLACE (State or foreign country) Alexandria, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Hubert Mills		14. MOTHER'S MAIDEN NAME Elizabeth Clements Newton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Charles N. Mills		Address 8321 Old Fort Rd. Wash. 22, DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain stem compression 237X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Brain tumor DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days 6 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 20, 1962 , to Apr 1, 1962 , that I last saw the deceased alive on March 29, 1962 , and that death occurred at 11:55P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE John T. Lord		M.D. 1015 Spring Street, Silver Spring, Md.	
PHYSICIAN'S NAME (Type) John T. Lord		DATE SIGNED 4/2/1962	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/5/1962	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co.		ADDRESS 517--11th St. S.E. Wash. DC	
24a. REC'D BY REGISTRAR DATE APR 5 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. CAUSE OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES H. HARRIS		Male		45		1880		Baltimore, Md.		Clerk		Married		Heart Disease		Baltimore, Md.		10:30 AM		J. H. Harris		J. H. Harris	
13. PLACE OF INTERMENT		14. NAME OF INTERMENT		15. DATE OF INTERMENT		16. NAME OF MINISTER		17. NAME OF CHURCH		18. NAME OF FUNERAL HOME		19. NAME OF CEMETERY		20. NAME OF FUNERAL HOME		21. NAME OF CEMETERY		22. NAME OF FUNERAL HOME		23. NAME OF CEMETERY		24. NAME OF FUNERAL HOME	
St. Paul's Episcopal Church		St. Paul's Episcopal Church		10/15/1925		Rev. J. H. Harris		St. Paul's Episcopal Church		J. H. Harris		St. Paul's Episcopal Church		J. H. Harris		St. Paul's Episcopal Church		J. H. Harris		St. Paul's Episcopal Church		J. H. Harris	

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL RECORD AS KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND.

WITNESSED MY HAND AND SEAL OF OFFICE THIS 15TH DAY OF OCTOBER, 1925.

J. H. HARRIS, REGISTRAR OF DEATHS, BALTIMORE, MARYLAND.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <i>md</i> b. COUNTY <i>montg</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Derwood</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>08 Derwood (rural)</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Redland Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Vernon George Mobley</i>		4. DATE OF DEATH <i>Apr 23 1962</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-26-1908</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>laborer</i>		11b. KIND OF BUSINESS OR INDUSTRY <i>-----</i>	9. AGE (in years last birthday) <i>53</i> yrs.
13. FATHER'S NAME <i>Geo Mobley</i>		14. MOTHER'S MAIDEN NAME <i>Carrie Taylor</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		17. INFORMANT <i>Landella Mobley - Sister</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> DUE TO <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>History of previous heart disease</i> DUE TO <i>420.1</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>History of previous heart disease</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.C.</i>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour e.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschert</i>		DATE SIGNED <i>4-23-62</i>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschert</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/25/62</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Derwood Cemetery</i>		22d. LOCATION (City, town, or country) (State) <i>Derwood, Maryland</i>	
23. FUNERAL DIRECTOR <i>Robert A. Pumphrey, Bethesda, Maryland</i>		24a. REC'D BY REGISTRAR <i>APR 26 '62</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanna</i>	

1870

1

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
 04783 **CERTIFICATE OF DEATH** 04782

1. PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE md. b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium & Hospital		d. STREET ADDRESS 6703 - 40th Ave.	
3. NAME OF DECEASED (Type or print) Glady's Luellen		4. DATE OF DEATH MODE 4 26 1962	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-17-11
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months 50 Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (County & State, or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Graham		14. MOTHER'S MAIDEN NAME Grace Hullett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute necrotizing bilateral Pneumonia DUE TO (b) Carcinoma of stomach 9 months DUE TO (c) generalized carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept 1961 , to April 26, 1962 , that (I) (we) last saw the deceased alive on April 26, 1962 , and that death occurred at 1:15 M , from the causes and on the date stated above.			
22a. SIGNATURE 22c. PHYSICIAN'S NAME (Type)		22b. DATE SIGNED 22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/30/62	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town or county) (State) Colmar Manor Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Halley's Funeral Home		25a. REC'D BY REGISTRAR DATE APR 30 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

DATE OF DEATH

NAME

(M)

Washington University Hospital

St. Louis, Mo.

11-11-11

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
04784 Item 23b, Film G 312 5/10/62 iwl										
04783										
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Virginia b. COUNTY Prince William c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manassas 83X-3 d. STREET ADDRESS 121 Polk Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Baby Boy "A"			4. DATE OF DEATH APRIL 30 19 62		5. SEX Male 6. COLOR OR RACE Caucasian 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 30 April 1962 9. AGE (In years last birthday) 4 10. IF UNDER 1 YEAR Months Days Hours Min. 14					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Walter C. MONTGOMERY					14. MOTHER'S MAIDEN NAME Alberta Ruth BRILEY					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 30, 1962 , to April 30, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 30, 1962 , and that death occurred at 8:30 PM the causes and on the date stated above.										
22a. SIGNATURE Frederic Schulaner M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> May 1, 1962			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) FREDERIC SCHULANER LT MC USN					22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF May 4, 1962		23c. NAME OF CEMETERY OR CREMATORY Memorial Cemetery		23d. LOCATION (City, town or county) (State) Hot Springs, Ark.			
24. FUNERAL DIRECTOR'S SIGNATURE Baker & Sons Mortuary, Manassas, Va.					25a. REC'D BY REGISTRAR MAY 7 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Finner			

2-001231

M
C
1

Neurology

Deceased (Rural)

U. S. Naval Hospital

Body

Boy

Neurology

April

SS

Unconscious

30 April 1962

X

England

Alberta Rich Military

Walter C. Montgomery

Hospital Records

NO

X

April 30, 1962

8:30 PM

April 30, 1962

XX May 1, 1962

U. S. Naval Hospital, Bethesda, Md.

Neurology

Boy

Neurology, Bethesda, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 only to be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61

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M
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04785

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04784

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Koolesville</u> c. LENGTH OF STAY IN b. <u>35 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Koolesville</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA M. J. MORNINGSTAR</u>		4. DATE OF DEATH Month Day Year <u>APRIL 14 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/26/1888</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>N. Y. State</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Frederick C. Reich</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Richard C. Morningstar Koolesville Md.</u> Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR THROMBOSIS</u> DUE TO <u>332</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>GENERALISED ARTERIOSCLEROSIS</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 MONTHS</u> <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SEVERE DECUBITUS ULCERS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 1961</u> , to <u>14 APRIL 1962</u> that (I) (we) last saw the deceased alive on <u>10 APRIL 1962</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE <u>John G. Fawcett</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>4/14/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN G. FAWCETT</u>		22d. ADDRESS <u>DAWSONVILLE P.O. BOYD, MD</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/17/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		23d. LOCATION (City, town or county) <u>Beallsville</u> (State) <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Constance C. Hilton</u> ADDRESS <u>Barnesville, Md.</u>		25a. REC'D BY REGISTRAR <u>17 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	



04330

CERTIFICATE OF DEATH

04330

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Montgomery

Montgomery

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John A. Towell

Boonville, Md.

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TO HOSPITAL, ON ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04788
CERTIFICATE OF DEATH
04787

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4425 Bradley Lane		d. STREET ADDRESS 4425 Bradley Lane	
3. NAME OF DECEASED (Type or print) First Polly Middle Cora Last Mulville		4. DATE OF DEATH Month April Day 15 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1910
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months 4 Days 8	
IF UNDER 24 HRS. Hours Min. 		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Mississippi	
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME Jessie T. Milligan	
14. MOTHER'S MAIDEN NAME (Unknown) Hallingsworth		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 577-48-6657		17. INFORMANT Edmund Mulville-Husband-same 2d	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) METASTATIC MELANOCARCINOMA TO 190.5 DUE TO BRAIN, LIVER, LUNG, BONE & SKIN. Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO MALIGNANT MELANOMA ABDOMINAL WALL		INTERVAL BETWEEN ONSET AND DEATH 8 months 2 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAY 6, 1961 , to APRIL 15, 1962 , that (I) (we) last saw the deceased alive on APRIL 13, 1962 , and that death occurred at 12:48 AM , from the causes and on the date stated above.			
22a. SIGNATURE J. Blaine Fitzgerald		22b. DATE SIGNED 4-15-62	
22c. PHYSICIAN'S NAME (Type) J. Blaine Fitzgerald		22d. ADDRESS 8218 Wisconsin Avenue Bethesda -	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/18/62	
23c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR APR 19 1962	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE	

04337

CENTINATA OF DEATH

04337



1. Name: [illegible]
2. Age: [illegible]
3. Sex: [illegible]
4. Race: [illegible]
5. Religion: [illegible]
6. Education: [illegible]
7. Occupation: [illegible]
8. Marital Status: [illegible]
9. Date of Birth: [illegible]
10. Date of Death: [illegible]
11. Cause of Death: [illegible]
12. Place of Death: [illegible]
13. Burial Place: [illegible]
14. Name of Burial Place: [illegible]
15. Name of Minister: [illegible]
16. Name of Officiant: [illegible]
17. Name of Witnesses: [illegible]
18. Name of Officiant: [illegible]
19. Name of Witnesses: [illegible]
20. Name of Officiant: [illegible]
21. Name of Witnesses: [illegible]
22. Name of Officiant: [illegible]
23. Name of Witnesses: [illegible]
24. Name of Officiant: [illegible]
25. Name of Witnesses: [illegible]

1. Name: [illegible]
2. Age: [illegible]
3. Sex: [illegible]
4. Race: [illegible]
5. Religion: [illegible]
6. Education: [illegible]
7. Occupation: [illegible]
8. Marital Status: [illegible]
9. Date of Birth: [illegible]
10. Date of Death: [illegible]
11. Cause of Death: [illegible]
12. Place of Death: [illegible]
13. Burial Place: [illegible]
14. Name of Burial Place: [illegible]
15. Name of Minister: [illegible]
16. Name of Officiant: [illegible]
17. Name of Witnesses: [illegible]
18. Name of Officiant: [illegible]
19. Name of Witnesses: [illegible]
20. Name of Officiant: [illegible]
21. Name of Witnesses: [illegible]
22. Name of Officiant: [illegible]
23. Name of Witnesses: [illegible]
24. Name of Officiant: [illegible]
25. Name of Witnesses: [illegible]

CERTIFICATE OF DEATH

04789

04788

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Germantown c. LENGTH OF STAY in 1b life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Brownstown				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland f. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown d. STREET ADDRESS Brownstown e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle A. Last MUMFORD				4. DATE OF DEATH Month April Day 22 Year 1962			
5. SEX female		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 2, 1909	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 52		IF UNDER 24 HRS. Hours 52		Min. 52	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S. A.							
13. FATHER'S NAME William Holly				14. MOTHER'S MAIDEN NAME Caroline Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. Riley Curtis		17. INFORMANT Boyd, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis with rt. hemiplegia 422.1 DUE TO (b) Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 8 March, 1962 to 22 April, 1962 , that (I) was last saw the deceased alive on 22 April 1962 , and that death occurred at 5:42 AM , from the causes and on the date stated above.							
22a. SIGNATURE Gordon M. Smith M.D. 22c. PHYSICIAN'S NAME (Type) Gordon M. Smith, M.D.				22b. DATE SIGNED 23 Apr 62 22d. ADDRESS Barnesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/25/62		23c. NAME OF CEMETERY OR CREMATORY Asbury Church.,		23d. LOCATION (City, town or county) (State) Germantown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden ADDRESS Rockville, Md.				25a. REC'D BY REGISTRAR DATE APR 30 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be signed by the hospital or attending physician. The law requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04791

04790

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital			2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, d. STREET ADDRESS 9704 51st Place, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Myhre			4. DATE OF DEATH Month Day Year April 25, 1962		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1962	9. AGE (In years last birthday) yrs. Months Days 31	IF UNDER 1 YEAR Months Days Hours Min. 31
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Donald Laverne Myhre			12. CITIZEN OF WHAT COUNTRY? America		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			17. INFORMANT Address Donna Clare Gray		
16. SOCIAL SECURITY NO. no			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Obstruction 527.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 10³⁰ AM 4/25 1962 to 4/25 1962 , that (I) (we) last saw the deceased alive on 4/25 1962 , and that death occurred at 11⁰⁰ AM , from the causes and on the date stated above.					
22a. SIGNATURE Raymond F. Chinn			22b. DATE SIGNED 4/25/62		
22c. PHYSICIAN'S NAME (Type) Raymond F. Chinn, M. D.			22d. ADDRESS 1110 Spring St., Silver Spring, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 4-26-62		23c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium & Hospital, Takoma Park, Md	
23d. LOCATION (City, town or county) (State)		24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M. D. Wash. San. & Hosp			
25a. REC'D BY REGISTRAR APR 30 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Hume			

Exposition Universelle - 1889

2/5/20

James Brown

04792

CERTIFICATE OF DEATH

Reg. Dist. No. 04791

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b <u>9 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Chestnut Lodge</u>				d. STREET ADDRESS <u>Dresden Apts, Connecticut Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Charlotte Campbell Nelson</u>				4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 15, 1863</u>	
9. AGE (In years last birthday) <u>99</u> yrs.		IF UNDER 1 YEAR Months <u>99</u> Days <u>99</u> Hours <u>99</u> Min. <u>99</u>		IF UNDER 24 HRS. <u>99</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Richmond, Virginia</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Duncan G. Campbell</u>				14. MOTHER'S MAIDEN NAME <u>ELEANOR CALVERT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Kenneth R. Gaarder</u> Address <u>500 W. Montgomery Ave Rockville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senile Arteriosclerosis</u> DUE TO (c) <u>10 years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-16-62</u> , 19 <u>62</u> , to <u>4-17-62</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>4-16-62</u> , 19 <u>62</u> , and that death occurred at <u>3:07 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Kenneth R. Gaarder</u> M.D.				ADDRESS (Street, city or town, state) <u>500 W. Montgomery Ave</u>			
PHYSICIAN'S NAME (Type) <u>Kenneth R. Gaarder, M.D.</u>				DATE SIGNED <u>Rockville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-18-1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gunderman, Inc. 1756 Pacific Ave.</u>				24a. REC'D BY REGISTRAR <u>Wash. D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>William E. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. This certificate may be relied upon by the funeral director, or other person, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

04793

CERTIFICATE OF DEATH

Reg. Dist. No. 04792

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON, D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ALTA VISTA NURSING HOME				d. STREET ADDRESS 6670 32nd STREET, N.W.			
3. NAME OF DECEASED (Type or print) IDA OESTRICHER				4. DATE OF DEATH Month APRIL Day 3 Year 1962			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 18, 1875	
9. AGE (In years lost birthday) 86 yrs.		IF UNDER 1 YEAR Months 86 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) NEW YORK	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME BERNARD HEIDINGSFELD				14. MOTHER'S MAIDEN NAME THERESA HOMBURGER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. ---			
17. INFORMANT MRS. BERNICE ARONOFF				ADDRESS 4500 CONN. AVE., N.W. WASHINGTON, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery Heart disease DUE TO (c) Generalized arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 1 month 10 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1950 , 19 50 , to 4/2 , 19 62 that I last saw the deceased alive on 3/26 , 19 62 , and that death occurred at 14 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2500 Calver St. N.W. DATE SIGNED PAUL R. WILNER							
ACTUAL SIGNATURE PAUL R. WILNER				PHYSICIAN'S NAME (Type) PAUL R. WILNER			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APRIL 5, 1962		22c. NAME OF CEMETERY OR CREMATORY MAIMONIDES CEMETERY		22d. LOCATION (City, town, or county) (State) ELMONT L.I. N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE Bernice Aronoff				ADDRESS 3501-14 ST. NW		24a. RECEIVED BY REGISTRAR DATE APR 6 1962	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

04794
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
04793

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md</u> b. COUNTY <u>mtg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>High Point - Wash. 16 DC</u>		c. LENGTH OF STAY IN 1b <u>6 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>High Point - Wash. 16 DC</u>		d. STREET ADDRESS <u>5831 Osceola ct</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5831 Osceola ct</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Marion Banks Outman</u> First Middle Last				4. DATE OF DEATH <u>apr 29 1962</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 9 1912</u> yrs. Months Days	
9. AGE (in years last birthday) <u>49</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>J. N. Banks</u>		14. MOTHER'S MAIDEN NAME <u>Ethel Spencer</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Boyd Outman (husband) Item 2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <u>sudden</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				22b. DATE THEREOF <u>5-1-1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	
22d. LOCATION (City, town, or country) <u>Suitland, Md.</u>				22e. REC'D BY REGISTRAR <u>Joseph G. Harrison, Inc. 1756 Park Ave NW</u>		22f. REGISTRAR'S SIGNATURE <u>ap 29 1962</u>	
23. FUNERAL DIRECTOR <u>Joseph G. Harrison, Inc. 1756 Park Ave NW</u>				23a. ADDRESS		23b. REGISTRAR'S SIGNATURE <u>ap 29 1962</u>	

MEDICAL CERTIFICATION

(M)

(X)

(1)

(2)

(B)

(M)

RECEIVED 21-10-55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04795 CERTIFICATE OF DEATH 04794

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 36 Kensington		d. STREET ADDRESS 3721 Emily Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle A. I. Last Parker, Jr.				4. DATE OF DEATH Month April Day 27 Year 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 3, 1925	
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months 36 Days 36 Hours 36 Min.		IF UNDER 24 HRS. Hours 36 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broker		10b. KIND OF BUSINESS OR INDUSTRY Stock Broker		11. BIRTHPLACE (County & State, or foreign country) Maryland Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James A. Parker, Sr.				14. MOTHER'S MAIDEN NAME Mariam Mettee			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 212-20-2052		17. INFORMANT (Doris Parker) wife		Address same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 152.0 DUE TO (b) splenic infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Resection of lymphosarcoma duodenum PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 1 hr							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Apr 17, 1962 to Apr 27, 1962 ; that (I) (we) last saw the deceased alive on Apr 27, 1962 , and that death occurred at 12:35 PM , from the causes and on the date stated above.							
22a. SIGNATURE John O. Robben				22b. DATE April 27, 1962		22c. PHYSICIAN'S NAME (Type) John O. Robben	
22d. ADDRESS 1015 Spring St. Silver Spring Md.				22e. REC'D BY REGISTRAR MAY 4 '62		22f. REGISTRAR'S SIGNATURE Arthur L. Thomas	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/30/62		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Prince George Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey				24b. ADDRESS Bethesda, Maryland		24c. REC'D BY REGISTRAR MAY 4 '62	

04205

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Montgomery

Between

Calvin Hospital

James

White

Robert

James A. Parker, Jr.

do

Maryland

Washington

1911-1912

A. I. Parker, Jr.

July 3, 1935

Stock Broker, Maryland Baltimore

John A. Parker

215-22-2052 (Doris Parker) wife

Montgomery

1911-1912

U.S.A.

Apr 25, 62

John O. Robert

4/30/62

Robert A. Bumsbury, Bethesda, Maryland

Dr. Lincoln Cemetery Prince George Co., Md.

Apr 17 12 40 PM '62

John O. Robert

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04796

CERTIFICATE OF DEATH

Item 9 Film G311 4/19/1962 mb

04795

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN 1b 10 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 812 Bowie Road		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 812 Bowie Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Kirk Patch First Middle Last 4. DATE OF DEATH April 12 1962 Month Day Year		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH May 19, 1921 40 41 yrs. 9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Gov't 10b. KIND OF BUSINESS OR INDUSTRY Retired 11. BIRTHPLACE (County & State, or foreign country) Michigan 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Gifford Patch 14. MOTHER'S MAIDEN NAME Frances Kirk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 2 16. SOCIAL SECURITY NO. 367-03-5843 17. INFORMANT Margaret Patch, Wife, same 2d Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia & respir. paralysis 48hrs DUE TO 237X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hydrocephalus (Internal) (c) Tumor of left ventricle PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) in determined	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 7/1/1946 to 4/12/1962 , that (I) (we) last saw the deceased alive on 4/12/1962 , and that death occurred at 7:30 P. from the causes and on the date stated above.			
22a. SIGNATURE Stephen N. Jones 22c. PHYSICIAN'S NAME (Type) Stephen N. Jones		22b. DATE SIGNED 4/13/62 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 809 Viers Mill Rd. Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4/16/62 23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery 23d. LOCATION (City, town or county) (State) Rockville, Maryland		24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland ADDRESS 25a. REC'D BY REGISTRAR APR 17 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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Montgomery

Montgomery

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Rockville

Rockville

112 Bowie Road

112 Bowie Road

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
04797											
04796											
1. PLACE OF DEATH a. COUNTY Montgomery						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Newfoundland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)						c. LENGTH OF STAY IN 1b 25 days					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Keith Alan PAVLISIN						4. DATE OF DEATH Month Day Year April 23, 1962					
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 1, 1962		9. AGE (In years last birthday) yrs. 2 Months 22 Days		IF UNDER 1 YEAR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -				10b. KIND OF BUSINESS OR INDUSTRY -				11. BIRTHPLACE (County & State, or foreign country) Newfoundland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank (n) Pavlisin						14. MOTHER'S MAIDEN NAME Viola Louise Bower					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Frank Pavlisin		Address Same as #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Possible Aspiration pneumonia 4-9-1 X DUE TO (b) Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Richmond County		(State) Maryland	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 29, 1962 to April 23, 1962, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 23, 1962, and that death occurred at 2:45AM from the causes and on the date stated above.											
22a. SIGNATURE F. A. Schulaner						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE April 23, 1962			
22c. PHYSICIAN'S NAME (Type) F. A. SCHULANER, LT MC USN						22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4-26-62		23c. NAME OF CEMETERY OR CREMATORY Haven Hill Bethesda, Md.		23d. LOCATION (City, town or county) Richmond County Olney, Illinois			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey						25a. REC'D BY REGISTRAR APR 26 '62		25b. REGISTRAR'S SIGNATURE Robert S. Kline			

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104138

CERTIFICATE OF DEATH

04707

Howland

Howland

Stymie

Stymie (Howland)

Howland, 13, May 1901

U. S. Naval Hospital

April 23, 1901

Howland

Howland

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Howland, 13, May 1901

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Howland, 13, May 1901

Howland (n) Howland

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April 23, 1901

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2:45 PM

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April 23, 1901

April 23, 1901

Howland

U. S. Naval Hospital, Howland, Me.

U. S. Naval Hospital, Howland, Me.

Howland, 13, May 1901

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Howland, 13, May 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04798

CERTIFICATE OF DEATH

04797

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 10 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Alexandria c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 83x3 d. STREET ADDRESS 1000 East Wakefield Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Grier Hartsell Peirce			4. DATE OF DEATH April 12 1962		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1903		9. AGE (In years last birthday) 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Natural Gas Engineer			10b. KIND OF BUSINESS OR INDUSTRY Federal Power Commission		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Stanley Peirce			14. MOTHER'S MAIDEN NAME Bertha Keston		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)			16. SOCIAL SECURITY NO. 300-10-5274		
17. INFORMANT The Medical Record			The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1 (b) Acute Myocardial infarction DUE TO (c) Hypertensive Cardiovascular disease with Congestive Heart Failure					INTERVAL BETWEEN ONSET AND DEATH 5-20 min. 20 min. 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I (this hospital) attended the deceased from April 2, 1962 to April 12, 1962, that I saw the deceased alive on April 12, 1962, and that death occurred at P.M. from the causes and on the date stated above.					
22a. SIGNATURE Edward L. Eyerman M.D.			22b. DATE SIGNED April 13, 1962		
22c. PHYSICIAN'S NAME (Type) Edward L. Eyerman, M.D.			22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 4/14/62	23c. NAME OF CEMETERY OR CREMATORY Lee's Crematorium	23d. LOCATION (City, town or county) Washington, D.C. (State)		
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Demaine & Son Funeral Home, Alexandria, Va.			25a. REC'D BY REGISTRAR APR 16 '62		
25b. REGISTRAR'S SIGNATURE Arthur L. Hume					

041015
OF 041015
041015

Virginia
Alexandria
In 1945

The Clinical Center, Bethesda, Md.
1000 East Wisconsin Avenue
Bethesda, Md. 20814

June 2, 1945
White
Federal Bureau of Investigation
Washington, D.C.

Re: [illegible]
The Clinical Center, Bethesda, Md.
1000 East Wisconsin Avenue
Bethesda, Md. 20814

Urie West
5-A-1111

Confidential
Investigative Division
Department of Health, Education & Welfare
Washington, D.C.

[illegible]

April 12, 1945
[illegible]

The Clinical Center, Bethesda, Md.
1000 East Wisconsin Avenue
Bethesda, Md. 20814

Washington, D.C.
[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04799 CERTIFICATE OF DEATH 04798

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN b 40 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLARKSVILLE		d. STREET ADDRESS 138-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Goulda First BELL Middle PICKETT Last				4. DATE OF DEATH Month 4 Day 24 Year 62			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-24-87 XXXXXXXX	
9. AGE (In years last birthday) 74 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME FRANK KEEFER				14. MOTHER'S MAIDEN NAME LYDIA SHRINER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHOLENIC NEPHROSIS, XXXX 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) BILIARY CIRRHOSIS DUE TO (c) CARCINOMA PANCREAS, HEAD						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/15/62 to 4/24/62 , that (I) (we) last saw the deceased alive on 4/24/62 , and that death occurred at 1:10P M, from the causes and on the date stated above.							
22a. SIGNATURE Charles S. Whitaker, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/25/62	
22c. PHYSICIAN NAME (Type) CHARLES S. WHITAKER, M.D.				22d. ADDRESS CLARKSVILLE, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-27-1962		23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		23d. LOCATION (City, town or county) (State) Winfield, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Box 241, Sykesville, Md.				25a. REC'D BY REGISTRAR MAY 1 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

8510

8510



LIBRARY
UNIVERSITY OF CALIFORNIA
LIBRARY

Charles S. Winter

3/3/65

VS A1S (4)
15M 9/SB

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be filed by the hospital or attending physician. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04801

CERTIFICATE OF DEATH

Items 13 & 14 Film G312 5/2/62 iwk

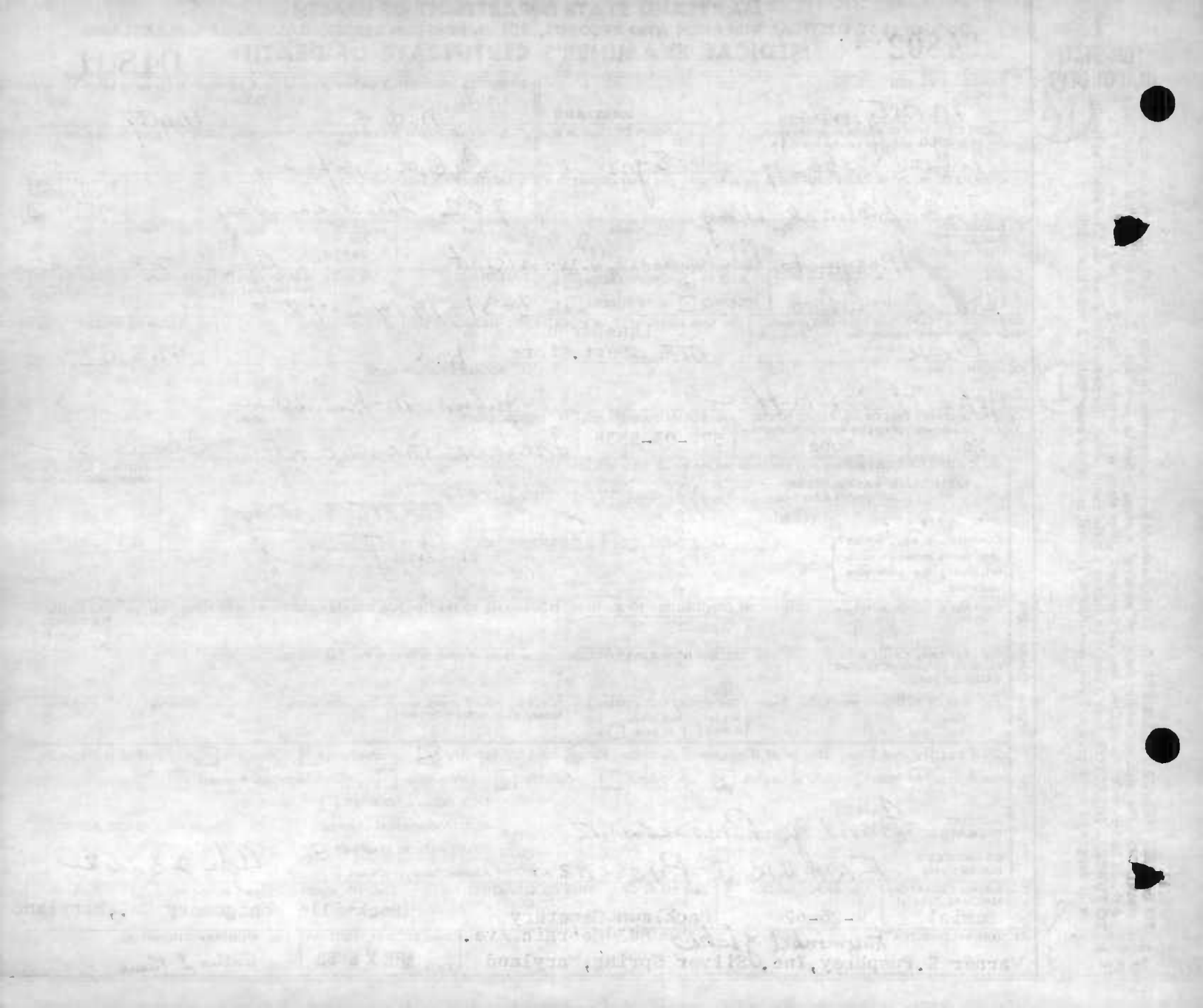
04800

1. PLACE OF DEATH a. COUNTY MONT. Co. b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Box 195 Olney, Md. c. LENGTH OF STAY IN 1b 7 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Brooke Grove Foundation			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONT. Co. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 29 Silver Springs d. STREET ADDRESS 1222 Pinecrest Circle e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) John I. Polek		4. DATE OF DEATH April 24 1962		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 12-18-1880		9. AGE (In years last birthday) 71		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (County & State, or foreign country) Bochnia Poland		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Casimir Polek	
14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO arteriosclerotic heart disease DUE TO diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 2 days 5-years 2 years		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Cerebral vascular thrombosis	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 4/18/62 to 4/24/62 , that (I) (we) last saw the deceased alive on 4/23/62 , and that death occurred at 2:48 PM from the causes and on the date stated above.					
22a. SIGNATURE John R. Spencer		M.D.		22b. DATE SIGNED 4-24-62	
22c. PHYSICIAN'S NAME (Type) John R. Spencer, M. D.		22d. ADDRESS BURTONSVILLE, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 4-28-62		23c. NAME OF CEMETERY OR CREMATORY Polary	
23d. LOCATION (City, town or county) Baltimore Md		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE F W Gzuzak Balto. Md		ADDRESS		25a. REC'D BY REGISTRAR APR 26 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Hump					

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MONTGOMERY STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
04802 04801											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY in 1b <u>5 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>30 Silver Spring</u>				d. STREET ADDRESS <u>1702 Lanack Way</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>702 Lanack Way</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Margaret Richardson Breinkent</u>						4. DATE OF DEATH <u>Apr 22 1962</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-31-1914</u>		9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>				11. BIRTHPLACE (State of foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>John H Snouffer</u>						14. MOTHER'S MAIDEN NAME <u>Julia McKindless</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>577-03-5338</u>		17. INFORMANT <u>Frederick Breinkent</u>		Address <u>Stim 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u>											
420.1 DUE TO <u>Coronary thrombosis</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschert</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED		
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Address (Street, city, town, or county) <u>Apr 23-62</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)					
<u>Burial</u>		<u>4-26-62</u>		<u>Parklawn Cemetery</u>		<u>Rockville Montgomery Co., Maryland</u>					
23. FUNERAL DIRECTOR <u>Raymond A. Giska</u>						Address <u>34 Georgia Ave.</u>		24a. REC'D BY REGISTRAR <u>APR 26 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
Warner E. Pumphrey, Inc. Silver Spring, Maryland											

MEDICAL CERTIFICATION



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04803

04802

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (rural)</u> c. LENGTH OF STAY IN 1b <u>45 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U.S. Naval Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>52 Chevy Chase</u> d. STREET ADDRESS <u>3119 Rolling Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Allen</u> Middle <u>Ingram</u> Last <u>PRICE</u>				4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>19 62</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 15, 1895</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Naval Officer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James Anderson Price</u>	
14. MOTHER'S MAIDEN NAME <u>Emily Gertrude Bissell</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Wife: Mrs. Elizabeth A. Price, Same as #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Confluent Lobular pneumonia</u> DUE TO (b) <u>Carcinoma mouth with metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (e) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1b.) <u> </u>			
20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that <u>X</u> (this hospital) attended the deceased from <u>February 26, 1962</u> to <u>April 11, 1962</u> , that <u>X</u> (we) last saw the deceased alive on <u>April 11, 1962</u> , and that death occurred at <u>7:00 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Vernon N. Houk</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>11 April 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>V.N. HOUK, LCDR MC USN</u>				22d. ADDRESS <u>U.S. Naval Hospital Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-16-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				25a. REC'D BY REGISTRAR <u>APR 16 '62</u>		25b. REGISTRAR'S SIGNATURE <u>S. K. K.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be filed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(continued)

(1012) 1012

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So, if the

NEW YORK, N.Y., MAY 15 (AP)—

2. *Microtus pennsylvanicus*

194, 155-160.

17
FOR STATE HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

04805

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04804

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookmont			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 58 Brookmont		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6330 Broad Street			d. STREET ADDRESS 6330 Broad Street		
3. NAME OF DECEASED (Type or print) John C Ramsey			4. DATE OF DEATH April 25 19 62		
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH May 5, 1893		9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR 11 Months 20 Days	
11. IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftsman		10b. KIND OF BUSINESS OR INDUSTRY North Carolina	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John S. Ramsey	
14. MOTHER'S MAIDEN NAME Mary Henderson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Edith Ramsey-Wife-same 2d	
17. INFORMANT Edith Ramsey-Wife-same 2d		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY 19 Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
21. ACTUAL SIGNATURE Frank J. Broschart		21. M.D. Assistant Medical Examiner <input type="checkbox"/> Deputy Medical Examiner <input checked="" type="checkbox"/>		21. DATE SIGNED 4/26/62	
21. EXAMINER'S NAME (Type) Frank J. Broschart		21. Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF 4/27/62		22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
22d. LOCATION (City, town, or country) Knox County, Kentucky		22e. REC'D BY REGISTRAR APR 30 '62			
22f. REGISTRAR'S SIGNATURE Arthur L. Kline		22g. REGISTRAR'S NAME			
23. FUNERAL DIRECTOR Robert A. Pumphrey, Bethesda, Maryland		23. ADDRESS			



John S. Ramsey
Mrs. Henderson
Edith Ramsey-Wilson

John S. Ramsey

NO

Raymond Hamilton

4/20/02

Robert A. Ramsey, Bettsville, Maryland, 4/27/02
Raymond Hamilton, 4/27/02
Knox County, Kentucky

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04805

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Gaithersburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R.F.D. # 3</u>		d. STREET ADDRESS <u>R.F.D. # 3</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Bundy Ranson</u>		4. DATE OF DEATH Month <u>Apr</u> Day <u>24</u> Year <u>1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 29-94</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Col U.S.A.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>	
11. BIRTHPLACE (State or foreign country) <u>DC</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.C</u>	
13. FATHER'S NAME <u>Stacy A Ranson</u>		14. MOTHER'S MAIDEN NAME <u>M. Levy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Helene Ranson (wife)</u>		Address <u>Stem 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u> </u> (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		DATE SIGNED <u>Apr 24-1962</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-27-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington</u> <u>PA</u>	
23. FUNERAL DIRECTOR <u>Ernest C. Gartner, Gaithersburg Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 30 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>C. L. Thomas</u>		24c. REGISTRAR'S SIGNATURE	

M

U.S. Department of Health
Washington, D.C.

1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be filled in by the attending physician and completed and filed in by the funeral director. After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04807
04806

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>12 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Resmor Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>47X-3</u> d. STREET ADDRESS <u>3217 19th St N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) First <u>FELICIA</u> Middle <u>Ann</u> Last <u>REEVE</u>		4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1962</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/13/77</u>		9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Tennessee</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Tennessee</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>											
13. FATHER'S NAME <u>Felix A. Reeve</u>				14. MOTHER'S MAIDEN NAME <u>Donelson</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Rest Home Records</u>				16. SOCIAL SECURITY NO. <u>Rest Home Records</u>				17. INFORMANT <u>Rest Home Records</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nephrosclerosis (Uremia)</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Generalized Arteriosclerosis</u> (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>2 years</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)												21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1953</u> to <u>April 19, 1962</u> , that (I) (the) last saw the deceased alive on <u>April 18, 1962</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Thomas S. Sappington</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>THOMAS S. SAPPINGTON</u>												ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>1025 CONNECTICUT AVE. WASH., D.C.</u>				22b. DATE SIGNED <u>4/19/62</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				23b. DATE THEREOF <u>4/24/62</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem. Ft. Myer, Va.</u>				23d. LOCATION (City, town or county) (State)											
24. FUNERAL DIRECTOR'S SIGNATURE <u>St. Hines Co</u>												ADDRESS <u>2901 14th N.W.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 23 '62</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

01016

CERTIFICATE OF DEATH

01016

(M)

State of Georgia

County of

City of

Dec 19 1901

Dec 19 1901

Dec 19 1901

Dec 19 1901

Dec 19 1901

Dec 19 1901

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Dec 19 1901

Dec 19 1901

Dec 19 1901

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Dec 19 1901

04808

CERTIFICATE OF DEATH

Reg. Dist. No. 04807

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 49 Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9001 Old Georgetown Road				d. STREET ADDRESS 9001 Old Georgetown Rd.			
3. NAME OF DECEASED (Type or print) Sister Mary First Mary Middle Rose Last Repos				4. DATE OF DEATH April 4 19 62			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-8-97		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Catholic Nun		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Portugal		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Manuel J. Repose				14. MOTHER'S MAIDEN NAME Anna Cardoza			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		INFORMANT Address Visitation Convent Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 3 3 1 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 19 50 to April 4, 19 62 that I last saw the deceased alive on 4-4 19 62 , and that death occurred at 6:45 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Michael J. McInerney				DATE SIGNED 4-4-62			
PHYSICIAN'S NAME (Type) Michael J. McInerney, M.D.				ADDRESS (Street, city or town, state) Washington, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-5-62		22c. NAME OF CEMETERY OR CREMATORY Visitation Convent		22d. LOCATION (City, town, or county) (State) Bethesda, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collier				ADDRESS 3821-14th St. N.W. Wash. DC		24a. REC'D BY REGISTRAR APR 6 '62	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be joined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

1805 CERTIFICATE OF DEATH

1805
Certificate of Death
Name: [illegible]
Age: [illegible]
Sex: [illegible]
Race: [illegible]
Date of Birth: [illegible]
Date of Death: [illegible]
Cause of Death: [illegible]
Place of Death: [illegible]
Signature: [illegible]
Witness: [illegible]
Registrar: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be removed by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it shall be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
04808											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Rockville c. LENGTH OF STAY IN 1b 3yrs. 11mos d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Waverley Sanitarium						2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE District of Columbia b. COUNTY ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 532 20th St., N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) BELLE TROTMAN RICHARDSON						4. DATE OF DEATH Month April Day 18 Year 19 62					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/4/1870		9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months 3 Days 13	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY --				11. BIRTHPLACE (County & State, or foreign country) USA			
13. FATHER'S NAME John Calvin Trotman						14. MOTHER'S MAIDEN NAME Mary Elizabeth Harrell					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ---				16. SOCIAL SECURITY NO. ---		17. INFORMANT Stanley P. Richardson Address Same as #2 above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombus 332X DUE TO Cerebral arterial sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Cerebral arterial sclerosis (c) Cerebral arterial sclerosis INTERVAL BETWEEN ONSET AND DEATH 3 days											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) ---							
20c. TIME OF INJURY Hour --- e.m. --- p.m. ---		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) --- (County) --- (State) ---			
21. I certify that (I) (this hospital) attended the deceased from Aug 13, 1962 to Apr 18, 1962 that (I) (we) last saw the deceased alive on Aug 17, 1962 and that death occurred at 9:00 M, from the causes and on the date stated above.											
22a. SIGNATURE Albert E. Marland, Sr.						22b. DATE SIGNED Apr 18, 1962			22c. PHYSICIAN'S NAME (Type) Albert E. Marland, Sr.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE THEREOF 4-20-1962		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City, town or county) Washington, D. C. (State) ---	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's Sons 1756 Pa., Ave., N.W.						25a. REC'D BY REGISTRAR APR 23 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Hines			

14

EX 108

04802

Republic of Colombia

Montgomery

Washington

Rural-Rockville

St. John's

Waverly

19 22

April

RICHARDSON

TRONAH

BILL

22

2/1/20

2/1/20

2/1/20

2/1/20

2/1/20

1922

--

House

Mr. Elizabeth Harvey

John Calvin Tronah

Stanley P. Richardson same as above

Albert E. Harland, Sr. 1915 10th St., N.W., Wash., D.C.

Albert E. Harland, Sr. 1915 10th St., N.W., Wash., D.C.

Washington, D.C.

Our Hill Cemetery

1900-1902

Joseph G. Grier, Jr.

1900 12.1.1902

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be signed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04810

04809

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton Md c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 12802 Hathaway Drive				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton Md. 34 d. STREET ADDRESS 12802 Hathaway Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Margaret Middle Mae Last Riley		4. DATE OF DEATH Month April Day 22 Year 19 62					
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 8, 1879		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own Home		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George Reeves				14. MOTHER'S MAIDEN NAME Ida Thomas			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT Idamae Garrott Wheaton, Md.			Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (b) Abdominal Carcinomatosis, Primary Undet. (c), stating the underlying cause last. (BIOPSY PROVED) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 199X						INTERVAL BETWEEN ONSET AND DEATH 1 week 2 mos. +	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-21-62, 19, to 4-22-62, 19, that (I) (we) last saw the deceased alive on 4-16-62, 19, and that death occurred at 11:58 PM, from the causes and on the date stated above.							
22a. SIGNATURE John P. Haberlin M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) John P. Haberlin, M.D.				22d. ADDRESS 1015 Spring St. Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 26, 1962		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE APR 25 '62	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04811

04810

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN b 4 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND f. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 32 SILVER SPRING d. STREET ADDRESS 13001 LAYHILL ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROSALIE NMN ROBEY		4. DATE OF DEATH Month Day Year APRIL 27 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-16-29
9. AGE (In years last birthday) 32 yrs.		10. IF UNDER 1 YEAR Months Days 32	11. IF UNDER 24 HRS. Hours Min. 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME ERNEST W. ROBEY		14. MOTHER'S MAIDEN NAME ALBERTA MCKENZIE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171x DUE TO Pyelonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Anemia DUE TO Adenocarcinoma of Cervix		INTERVAL BETWEEN ONSET AND DEATH 1 mo 2 mo 15 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from APRIL 23 , 19 62 , to APRIL 27 , 19 62 , that (I) (we) last saw the deceased alive on Nov 27 1962 , and that death occurred at 11:30 PM from the causes and on the date stated above.			
22a. SIGNATURE C.H. LIGDN, M.D.		22b. DATE SIGNED 4/28/62	
22c. PHYSICIAN'S NAME (Type) C.H. LIGDN, M.D.		22d. ADDRESS SANDY SPRING, MARYLAND	
23a. BURIAL, CREMATION, or other disposal (Specify)	23b. DATE THEREOF 5/1/62	23c. NAME OF CEMETERY OR CREMATORY Union Cemetery	23d. LOCATION (City, town or county) (State) BARTONSVILLE, MD
24. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS Co - Silver Spring, Md		25a. REC'D BY REGISTRAR MAY 2 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

M

MONTGOMERY

ALLEY

H. DAVIS

1100 E. 10TH

OUT CHIEF GENERAL

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Psychiatry

James

Donovan

1100 E. 10TH

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1100 E. 10TH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04812
CERTIFICATE OF DEATH
04811

1. PLACE OF DEATH e. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1004 Crawford Drive		2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) e. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 1004 Crawford Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARY (Mammie) M. Romsburg		4. DATE OF DEATH Month Day Year 4 - 23 - 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-4-1903
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book keeper		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME A. Windsor Davis		14. MOTHER'S MAIDEN NAME Nora Browning	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-14-7020	
17. INFORMANT Mr. Paul L. Romsburg		1004 Crawford Drive Rockville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 174X DUE TO Conditions, if any, which gave rise to immediate cause (b) Blurred uterus (c) Adenocarcinoma of uterus & metastases DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 yrs INTERVAL BETWEEN ONSET AND DEATH 1 wk. 2 wks.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/1/1954 to 4/23/1962 that (I) (we) last saw the deceased alive on 4/23/1962 and that death occurred at 8:15 AM from the causes and on the date stated above.			
22a. SIGNATURE Dr. Jones		22b. DATE SIGNED 4/23/62	
22c. PHYSICIAN'S NAME (Type) Dr. Jones		22d. ADDRESS M.D. Medical Center Rockville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-28-1962	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City, town or county) (State) Frederick, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Bailey & Son		25a. REC'D BY REGISTRAR DATE MAY 2 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Kenna			

19813

Montgomery

Rockville

1001 Crawford Drive

Years

Rockville

Montgomery

Montgomery

1001 Crawford Drive

(Name)

X

Female White

11-1-1903

58

Book keeper

None

Frederick Co., Maryland

U.S.A.

A. Windsor Davis

None

1001 Crawford Drive

Rockville, Maryland

11-1-1900 Mr. Paul L. Rosenberg

No

1-20-1900

Mr. Oliver Cemetery

Frederick, Maryland

Robert E. Bailey's Son

Frederick, Maryland

James

M.D. National Cemetery, Rockville, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04813											
04812											
Item 8 Film 0311 4/18/62 mh											
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SUBURBAN HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 CHEVY CHASE d. STREET ADDRESS 1 8908 MONTGOMERY AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MAX			First Middle Last F. ROSINSKI			4. DATE OF DEATH APRIL 14 19 62			Day Year		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/23/69 68		9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10b. KIND OF BUSINESS OR INDUSTRY CABINET MAKER				11. BIRTHPLACE (County & State, or foreign country) GERMANY		12. CITIZEN-OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carl Rosinski						14. MOTHER'S MAIDEN NAME Marie Ribnitzki					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address D.C. Anne R. Fox Daughter 5122 N. Capitol St., N.W.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 Infarction, small intestine DUE TO (b) Thrombosis, Superior Mesenteric Artery DUE TO (c) Atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. None 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from Dec. 19 58 to 4/14, 1962; that (I) (we) last saw the deceased alive on 4/13 1962, and that death occurred 8:30 AM, from the causes and on the date stated above. 22a. SIGNATURE John B. Vinham M.D. 22b. DATE SIGNED 4/14/62 22c. PHYSICIAN'S NAME (Type) JOHN B. Vinham 22d. ADDRESS 8805 Conn Ave Chevy Chase Md 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF APR. 17, 1962 23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S 23d. LOCATION (City, town or county) (State) WASH. D.C. 24. FUNERAL DIRECTOR'S SIGNATURE Geier Funeral Home 3605 14th St NW Wash D.C. 25a. REC'D BY REGISTRAR DATE APR 17 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus											

00113

00113



10/15/1913
10/15/1913
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10/15/1913

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04814

04813

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Echo</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>16 Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>1 evening</u>				d. STREET ADDRESS <u>1619 Oakview Dr</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Glen Echo Amusement Park</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edward William Rothblum</u>				4. DATE OF DEATH Month Day Year <u>April 19 1962</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-27-44</u>	
9. AGE (In years last birthday) <u>17</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		11. BIRTHPLACE (State or foreign country) <u>Pensacola Fla.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Rothblum</u>				14. MOTHER'S MAIDEN NAME <u>MARY Elizabeth Stone</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>213-44-7473</u>		17. INFORMANT <u>Brother - Richard Rothblum</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Transsection of cervical spinal cord</u> 912.4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture & dislocation C-6 vertebrae</u> (c) <u>Multiple injuries</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell off + ran over by roller coaster</u>			
20c. TIME OF INJURY Month, Day, Year Hour :mm <u>10:30 p.m. 4-19 1962</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Amusement Park</u>	
20f. (City or town) <u>Glen Echo monty</u>				20g. (County) <u>md</u>		20h. (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brotsch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brotsch</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. REC'D BY REGISTRAR DATE <u>APR 23 '62</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			
22b. DATE THEREOF <u>4-21-62</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>			
22d. LOCATION (City, town, or country) <u>Prince George's Co., Maryland</u>				22e. (State) <u>Md</u>			
23. FUNERAL DIRECTOR <u>Raymond A. Jiska</u>				23a. ADDRESS <u>8434 Georgia Ave.</u>			
23b. NAME <u>Warner E. Pumphrey, Inc.</u>				23c. CITY, STATE, AND ZIP <u>Silver Spring, Maryland</u>			

MEDICAL CERTIFICATION

M

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BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and completely fill in by the funeral director, page 4. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and completely fill in by the funeral director, page 4.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 15 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE New Jersey b. COUNTY ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Rock d. STREET ADDRESS 150 Fairmont Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Harvey (No middle name) Rowitz		4. DATE OF DEATH Month April Day 10 Year 19 62				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 June 1928	9. AGE (In years last birthday) 33 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10b. KIND OF BUSINESS OR INDUSTRY Law		11. BIRTHPLACE (County & State, or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Irving Rowitz		14. MOTHER'S MAIDEN NAME Rose Grobart				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) No		16. SOCIAL SECURITY NO. 142-20-7513		17. INFORMANT The Medical Records, The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 456X DUE TO Wegener's Granulomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 8 1/2 months						INTERVAL BETWEEN ONSET AND DEATH 1 hr. 35 min.
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 26 19 62 to April 10 19 62 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 10 19 62 , and that death occurred at 11:45 A.M. from the causes and on the date stated above.						
22a. SIGNATURE Thomas R. Cate		M.D. Thomas R. Cate, M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> April 10, 1962		22b. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 12, 1962		23c. NAME OF CEMETERY OR CREMATORY Cedar Park Cemetery		23d. LOCATION (City, town or county) (State) Emerson, N.J.
24. FUNERAL DIRECTOR'S SIGNATURE Gooding Funeral Home		ADDRESS 4217-9th Ave		25a. REC'D BY REGISTRAR APR 12 '62		25b. REGISTRAR'S SIGNATURE Walter L. Thomas

Division of
04816

VS. AISME
SM 9/60

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Faithsburg - R-2</u> c. LENGTH OF STAY IN 1b <u>3 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Manchester mill Rd</u>		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>124 Faithsburg RD # 2</u> d. STREET ADDRESS <u>Manchester mill Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Glenn Marie Runion</u> First Middle Last 5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>2-13-07</u> 9. AGE (In years last birthday) <u>55</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH <u>Apr 13 1962</u> Month Day Year 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>Va</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bramon Jenkins</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year and dates of service) 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Raymond Runion (husband)</u> Address <u>Stn 2</u>		14. MOTHER'S MAIDEN NAME <u>Savinia May Jenkins</u> 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) DATE SIGNED <u>4-13-62</u>	
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D. EXAMINER'S NAME (Type) <u>FRANK J. BROSCHELT</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>April 16 1962</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u> 22d. LOCATION (City, town, or country) (State) <u>Rockville Md.</u>		23. FUNERAL DIRECTOR <u>Francis H. Barber</u> ADDRESS <u>Laytonsville, Md.</u> 24a. REC'D BY REGISTRAR <u>APR 17 1962</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

0818

0818

entirely new

none

no

no

no

no

no

120
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>						c. LENGTH OF STAY in lb <u>50A. 3pm</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hosp.</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING 24</u>					
3. NAME OF DECEASED (Type or print) First <u>MAURICE</u> Middle <u>O</u> Last <u>RYAN</u>						4. DATE OF DEATH Month <u>4</u> Day <u>8</u> Year <u>1962</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-2-1899</u>		9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager Am. Hotel Assoc</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>mith</u>					
11. BIRTHPLACE (State or foreign country) <u>MD.</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>					
13. FATHER'S NAME <u>Leslie Ryan</u>						14. MOTHER'S MAIDEN NAME <u>Candry Orlton</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES 1947-19</u>						16. SOCIAL SECURITY NO. <u>501-03 3097</u>					
17. INFORMANT <u>Ellen Ryan (wife)</u>						Address <u>Ilwaco 2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u>19</u>		Month, Day, Year <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Birschant</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. BIRSCHANT</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>4-11-1962</u>					
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Ce, etery, Arlington, Va.</u>						22d. LOCATION (City, town, or country) (State)					
23. FUNERAL DIRECTOR <u>Joseph Gauler</u>						24a. REC'D BY REGISTRAR <u>APR 12 '62</u>					
ADDRESS <u>1756 Pa Ave</u>						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>					

M

1

4-11-1968, Arlington, Va.
[Illegible text]

CERTIFICATE OF DEATH

04817

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood			
c. LENGTH OF STAY in 1b Newborn				d. STREET ADDRESS 4508 39th Street			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PAUL Middle (N) Last Rzasa				4. DATE OF DEATH Month April Day 20 Year 1962			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 20, 1962	
9. AGE (In years last birthday) 0		IF UNDER 1 YEAR Months 0 Days 2		IF UNDER 24 HRS. Hours 0 Min. 2			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Bethesda, Maryland	
						12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Anthony Joseph Rzasa				14. MOTHER'S MAIDEN NAME FLORENCE V. BIEDZYNSKI			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No				16. SOCIAL SECURITY NO. (F) ANTHONY J. RZASA			
				17. INFORMANT SAME AS # 2 ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia, Neonatorium DUE TO (b) Dystocia, fetal DUE TO (c) Breech, locked chin to symphysis							INTERVAL BETWEEN ONSET AND DEATH 2 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 20 April , 1962, to 20 April , 1962, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 20 April , 1962, and that death occurred at 1112 AM the causes and on the date stated above.							
22a. SIGNATURE Joel S. Goodwin M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4-21-62	
22c. PHYSICIAN'S NAME (Type) Joel S. Goodwin, LT MC USN				22d. ADDRESS U.S. NAVAL HOSPITAL, BETHESDA, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-25-62		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers ADDRESS 517 11th St. Washington, D.C.				25a. REC'D BY REGISTRAR APR 24 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

2-002062

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)
(C)

IDENTIFICATION

Section (A) (a)

U. S. Naval Hospital

PAUL
KIDNEY

(H)
KIDNEY

Continuation

Male

April 20, 1965

Barbados, Barbados

USA

YOUNG, V. HINDS, JR.

Section (A) (a)

(Y) ANTHONY J. BRYAN 8/16/45 4' 8" ABOVE

Section (A) (a)
Section (A) (a)

Section (A) (a)
Section (A) (a)

April 20, 1965

ALL IN

CS

April 20, 1965

April 20, 1965

XX

U. S. Naval Hospital, BARBADOS, BARBADOS

U. S. Naval Hospital, BARBADOS, BARBADOS

Virginia

Virginia

Virginia

April 20, 1965

U. S. Naval Hospital, BARBADOS, BARBADOS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04819

WT. 11lb 9oz

04818

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>2 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>11 Rockville</u> d. STREET ADDRESS <u>12800 Atlantic Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>PETER ALFRED BOY</u> <u>SANTE</u>			4. DATE OF DEATH Last Month Day Year <u>April 2 1962</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2 1962</u>	9. AGE (In years last birthday) yrs. <u>2</u>	IF UNDER 1 YEAR Months Days <u>2</u> IF UNDER 24 HRS. Hours Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>JULIAN EDWARD SANTE</u>			14. MOTHER'S MAIDEN NAME <u>MARGARET ELIZABETH SMITH</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>MOTHER. SAME AS ABOVE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTRA CRANIAL Hemorrhage</u> <u>760.5</u> DUE TO (b) <u>PREMATURITY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>-</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2h</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/2</u> , <u>1962</u> to <u>4/2</u> , <u>1962</u> , that (I) (we) last saw the deceased alive on <u>4/2</u> , <u>1962</u> , and that death occurred at <u>10A</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>Richard H Fischer</u>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <u>RICHARD H FISCHER MD.</u>			22d. ADDRESS <u>4630 MONTGOMERY AVE BETHESDA MD</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/4/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Catholic</u>		23d. LOCATION (City, town or county) (State) <u>Rockville, Montgomery Co., Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u> <u>1331-E, Montgomery Ave, Rockville, Maryland</u>			25a. REC'D BY REGISTRAR <u>APR 5 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Clara P. H.</u>

2-010316



01818

01818

THE UNIVERSITY OF CHICAGO
LIBRARY

From the University of Chicago
Library
Chicago, Illinois
1918

12
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.
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MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>					
c. LENGTH OF STAY IN 1b <u>3 yrs</u>						d. STREET ADDRESS <u>51 Walnut Ave</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>51 Walnut Ave</u>						a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Nellie A. SAUVE</u>						4. DATE OF DEATH <u>Apr 28 1962</u>					
5. SEX <u>Female</u>						6. COLOR OR RACE <u>white</u>					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>Oct 23 73</u>					
9. AGE (In years last birthday) <u>88</u> yrs.						10. IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) <u>Pa</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>					
13. FATHER'S NAME <u>James Sweeney</u>						14. MOTHER'S MAIDEN NAME <u>Mary Carden</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						16. SOCIAL SECURITY NO. <u>Helen Koiss - (deceased) Item 2</u>					
17. INFORMANT Address <u>Helen Koiss - (deceased) Item 2</u>						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>420</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town) (County) (State)						21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
CHIEF MEDICAL EXAMINER <input type="checkbox"/>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <u>2</u>						DATE SIGNED <u>4-28-62</u>					
Address (Street, city, town, or county)						22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					
22b. DATE THEREOF <u>MAY 1, 1962</u>						22c. NAME OF CEMETERY OR CREMATORY <u>ST. RAYMOND CEMETERY</u>					
22d. LOCATION (City, town, or country) (State) <u>BRONX N.Y.</u>						23. FUNERAL DIRECTOR <u>Arthur S. Kline</u>					
24a. REC'D BY REGISTRAR <u>APR 30 '62</u>						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>					

MEDICAL CERTIFICATION

91819

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE HEALTH DEPT.

M

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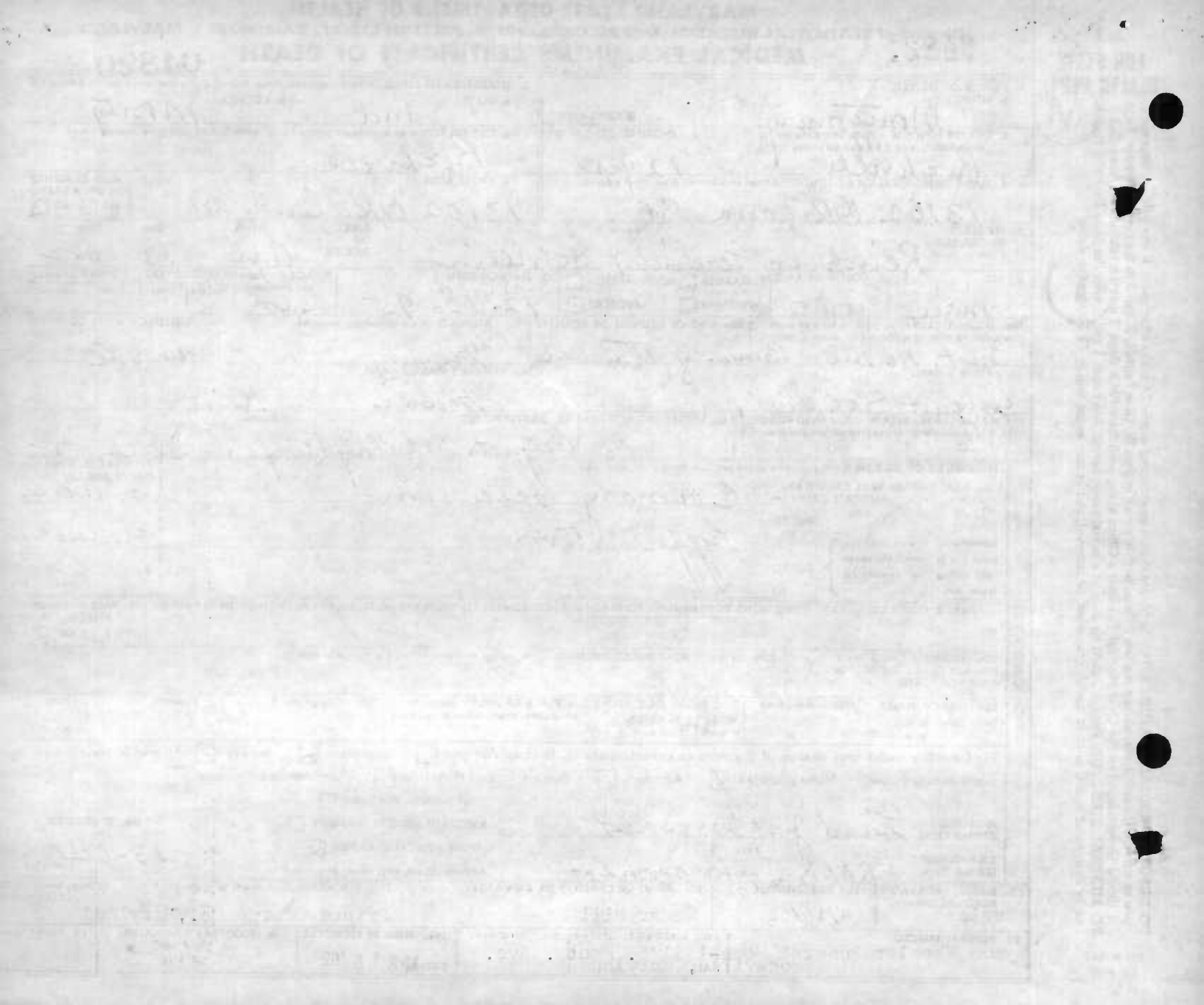
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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04821 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04820

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN lb <u>12 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>11 Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>13102 Okinawa Rd</u>				d. STREET ADDRESS <u>13102 Okinawa Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Reinhold Ferdinand Schilling</u>				4. DATE OF DEATH Month <u>Apr</u> Day <u>13</u> Year <u>1962</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-18-95</u>	9. AGE (In years last birthday) <u>66 yrs.</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inst. maker Bureau of Standards</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Germany</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>August Schilling</u>				14. MOTHER'S MAIDEN NAME <u>Helena Kurt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Augusta Schilling (wife)</u> Address <u>Stem 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DU TO <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DU TO <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u>62</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Prince George Co., Maryland</u>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. <u> </u>		DATE SIGNED <u>4-13-62</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		Address (Street, city, town, or county) <u> </u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/16/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or country) (State) <u>Prince George Co., Maryland</u>	
23. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>APR 16 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04822
CERTIFICATE OF DEATH
04821

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 Kensington	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4512 Saul Road		d. STREET ADDRESS 4512 Saul Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Agnes Last Schofield		4. DATE OF DEATH Month April Day 23 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1894 67 yrs.
9. AGE (In years last birthday) 67 yrs.		10. MONTHS 11 DAYS 26	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Fallon		14. MOTHER'S MAIDEN NAME Ella Kennan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Henry N. Schofield-Husband-Same		Address 2d	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) cardiovascular collapse DUE TO (b) acute myocardial infarction DUE TO (c) generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. cerebral vascular accident		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) cerebral vascular accident		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 1956 to April 1962 that (I) (we) last saw the deceased alive on April 23, 1962 and that death occurred at 1:25 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Wilfred R. Ehrmantraut M.D.		22b. DATE SIGNED 4/24/62	
22c. PHYSICIAN'S NAME (Type) Wilfred R. Ehrmantraut		22d. ADDRESS 4890 Battery Lane, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/26/62	
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION (City, town or county) (State) Silver Spring, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
25a. REC'D BY REGISTRAR APR 26 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hallinan	

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FOR STATE
HEALTH DEPT. M
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

<div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>04823</p> </div> <div> <p>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</p> <p>04822</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in lb <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hosp</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>34 Wheaton</u> d. STREET ADDRESS <u>3910 Elby St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Lester Samuel Scott</u> First Middle Last 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept 24-94</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (If years last birthday) <u>67</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Business Executive - Plummer Co.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>min.</u> 11. BIRTHPLACE (State or foreign country) <u>U.S.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>						13. FATHER'S NAME <u>Walter Scott</u> 14. MOTHER'S MAIDEN NAME <u>Anna Hawley</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> 16. SOCIAL SECURITY NO. <u>1914-18 578-09-328</u> 17. INFORMANT <u>Eliz. Scott - Sister</u> Address <u>2</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 420.1 DUE TO <u>Hemorrhage into arteriosclerotic plaque of coronary artery</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>Arteriosclerosis, coronary</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>None</u> INTERVAL BETWEEN ONSET AND DEATH <u>Four hours</u> <u>Months</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Fell in bath room at home</u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour <u>2:30</u> p.m. Month, Day, Year <u>4-22-62</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u> 20f. (City or town) <u>Wheaton</u> (County) <u>mntg</u> (State) <u>md</u>											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Frank J. Brosehan</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>FRANK J. BROSEHAN</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> 22b. DATE THEREOF <u>4/25/62</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u> 22d. LOCATION (City, town, or country) <u>Ft. Myer, Va.</u> (State) <u>md</u> 23. FUNERAL DIRECTOR <u>The S.H. Hines Co.</u> 24a. REC'D BY REGISTRAR <u>APR 24 '62</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hays</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04824

04823

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE <u>New York</u> b. COUNTY <u>Rensselaer</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hoosick Falls</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>			d. STREET ADDRESS <u>140 Main Street</u>		
3. NAME OF DECEASED (Type or print) <u>Sylvester E. Scott</u>			4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1962</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 8, 1888</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>7</u>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>
13. FATHER'S NAME <u>Edmund Scott</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>			14. MOTHER'S MAIDEN NAME <u>Mary Newman</u>		
16. SOCIAL SECURITY NO. <u>Unknown</u>			17. INFORMANT <u>Mrs. Richard Bryant/11831 Falls Rd.-Rockville, Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Intracerebral hemorrhage, massive</u> 331X DUE TO <u>Arteriosclerosis, cerebral</u> right Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 7, 1962</u> to <u>April 15, 1962</u> that (I) (we) last saw the deceased alive on <u>April 14, 1962</u> and that death occurred <u>12:30 PM</u> , from the causes and on the date stated above.					
22e. SIGNATURE <u>G. Bowditch Hunter, Jr.</u> M.D.			22b. DATE SIGNED <u>April 15, 1962</u>		
22c. PHYSICIAN'S NAME (Type) <u>G. BOWDITCH HUNTER, JR.</u>			22d. ADDRESS <u>809 Viers Mill Rd, Rockville, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 4-16-62</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	
23d. LOCATION (City, town or county)		23e. REGISTRAR'S SIGNATURE <u>Robert A. Pumpkins</u>		23f. REGISTRAR'S SIGNATURE <u>Robert A. Pumpkins</u>	
23g. ADDRESS <u>Bethesda, Md.</u>		23h. REC'D BY REGISTRAR <u>APR 19 1962</u>		23i. REGISTRAR'S SIGNATURE <u>Robert A. Pumpkins</u>	

04828

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For information, please
contact Special Agent in Charge,
New York Office.

Enclosed for the New York Office are two copies of a letterhead memorandum dated 4-18-62, captioned "RE: [illegible]".
Very truly yours,
[illegible]
Special Agent in Charge

1
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

<div> <div>04825</div> <div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> <div>04824</div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg (rural)</u> c. LENGTH OF STAY IN lb <u>2 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pond on Transon Farm</u>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mnty</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg (rural)</u> d. STREET ADDRESS <u>R 70 #1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Lee</u> Last <u>Seller</u>						4. DATE OF DEATH Month <u>Apr</u> Day <u>26</u> Year <u>1962</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-12-56</u>		9. AGE (In years last birthday) <u>5</u> yrs. IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u>		IF UNDER 24 HRS. Hours <u>5</u> Min. <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Harlan W. Sell</u>						14. MOTHER'S MAIDEN NAME <u>Catherine S. Shipe</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Harlan W. Sell Rt. #1 Gaithersburg, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO <u>Choking</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u>1850x</u> (b) <u>Choking</u> DUE TO <u>Choking</u> (c) <u>Choking</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sudden</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Was boating on pond and drowned</u> 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>10:30</u> p.m. <u>4-26-1962</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Pond</u> 20f. (City or town) <u>Gaithersburg</u> (County) <u>R-1 mnty</u> (State) <u>md</u>											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>4-26-62</u>											
ACTUAL SIGNATURE <u>Frank J. Brosch</u> EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>				DATE SIGNED <u>4-26-62</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4-29-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Goshen</u>			22d. LOCATION (City, town, or country) <u>Goshen, Mont.</u> (State) <u>Maryland</u>		
23. FUNERAL DIRECTOR <u>Francis H. Barber</u> ADDRESS <u>Laytonsville, Md.</u>						24a. REC'D BY REGISTRAR DATE <u>APR 30 '62</u>			24b. REGISTRAR'S SIGNATURE <u>Charles L. Hume</u>		

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be completed by the hospital or attending physician. Page 2 may be completed by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
04825											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FAIRLAND NURSING HOME</u>						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>20 TAKOMA PARK</u> d. STREET ADDRESS <u>1 TOO BAYFIELD ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>SARAH</u> First <u>SHAPIRO</u> Middle <u>SHAPIRO</u> Last			4. DATE OF DEATH Month <u>4</u> Day <u>14</u> Year <u>1962</u>			5. SEX <u>F</u>			6. COLOR OR RACE <u>W</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>JUNE 3, 1888</u>			9. AGE (In years last birthday) <u>73</u> yrs.			IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>RUSSIA</u>			11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>ABRAHAM KLEBANOFF</u>						14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)			16. SOCIAL SECURITY NO. <u>NONE</u>			17. INFORMANT <u>DEBBY A. SHAPIRO</u> Address <u>SON</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic Carcinoma</u> <u>170X</u> DUE TO (b) <u>Carcinoma of Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u> </u>									INTERVAL BETWEEN ONSET OF DEATH <u>3 months</u> <u>18 months</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1944</u> , 19 <u> </u> , to <u>4/14</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>4/14</u> , 19 <u>62</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Irving W. Winik</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>4/15/62</u>		
22c. PHYSICIAN'S NAME (Type) <u>Irving W. Winik</u>						22d. ADDRESS <u>3900 McKinley St. N.W.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>4/16/62</u>			23c. NAME OF CEMETERY OR CREMATORY <u>NAT'L CAP. HEB. CEM.</u>			23d. LOCATION (City, town or county) (State) <u>WASH. DC.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u> ADDRESS <u>4217 9th St. N.W.</u>						25a. REC'D BY REGISTRAR DATE <u>APR 19 '62</u>			25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

CERTIFICATE OF DEATH

Reg. Dist. No. 04826

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING 34			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BEL PRE NURSING HOME				d. STREET ADDRESS 12717 HODDRIDGE ROAD			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last SUSIE SHEAR				4. DATE OF DEATH Month Day Year APRIL 24, 1962 19			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 15, 1904		9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME MORRIS ROSENBERG				14. MOTHER'S MAIDEN NAME REBECCA ---			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. UNKNOWN			
INFORMANT 14207 CHADWICK LANE				IRVING SHEAR ROCKVILLE, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral arteriosclerosis 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) gen'itized DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 wks 4 yrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/19/62 to 4/24/62 that I last saw the deceased alive on 4/14/62 , 19 62 , and that death occurred at 11:05 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald Nelson				ADDRESS (Street, city or town, state) DATE SIGNED M.D. 10620 Georgia Ave. Silver Spring 4/24/62			
PHYSICIAN'S NAME (Type) DONALD NELSON, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-27-62		22c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN		22d. LOCATION (City, town, or county) (State) FALLS CHURCH VA.	
23. FUNERAL DIRECTOR'S SIGNATURE BERNARD DANZANSKY & SONS				ADDRESS 3501 14th St. N		24a. REC'D BY REGISTRAR APR 30 '62	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1924

NAME OF DECEASED JOHN ROBERTSON
RESIDENCE 1000 10th St. N.W.
CITY WASHINGTON STATE D.C.

DATE OF DEATH April 11, 1924
PLACE OF DEATH Home

CAUSE OF DEATH Heart Disease
MANNER OF DEATH Natural

SIGNATURE OF PHYSICIAN Dr. J. H. Smith
DATE April 12, 1924

SIGNATURE OF WITNESSES John A. Brown
Mary E. Jones

SIGNATURE OF REGISTRAR John D. Smith
DATE April 12, 1924

PLACE OF BIRTH Scotland
AGE 65 YEARS

SEX Male
OCCUPATION Teacher

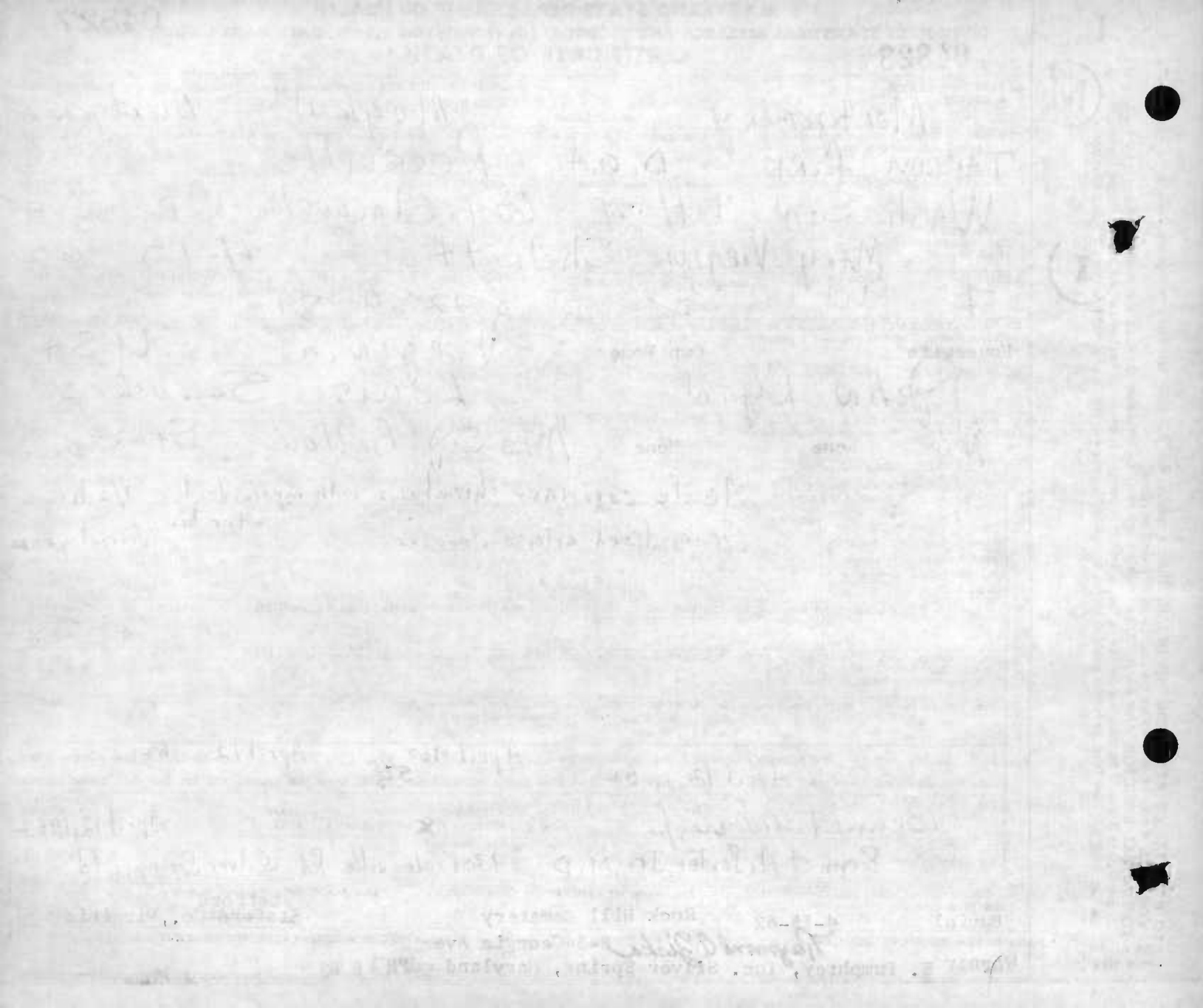
EDUCATION High School
RELIGION Methodist

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>09 Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash Stn & Hosp</u>		d. STREET ADDRESS <u>624 Edmonston Dr</u>	
3. NAME OF DECEASED (Type or print) <u>Mary Virginia Shelkett</u>		4. DATE OF DEATH <u>4-12-1962</u>	
5. SEX <u>F</u>	6. COLOR OF RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-22-80</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Ryan</u>		14. MOTHER'S MAIDEN NAME <u>Louise Saunders</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. E. J. Ballou - Same above.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis with myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr</u> <u>Several years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 1960</u> to <u>April 12, 1962</u> ; that (I) (we) last saw the deceased alive on <u>April 12, 1962</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.		22a. SIGNATURE <u>Bennet A. Porter, Jr.</u> M.D.	
22b. DATE SIGNED <u>April 12, 1962</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr., M.D.</u>		22d. ADDRESS <u>9301 Colesville Rd, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-15-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Hill Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Stafford Co., Virginia</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		25. REC'D BY REGISTRAR <u>Warner E. Pumphrey, Inc. Silver Spring, Maryland</u>	
25b. REGISTRAR'S SIGNATURE <u>Warner E. Pumphrey</u>		DATE <u>APR 16 '62</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
04829						04828							
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (rural) c. LENGTH OF STAY IN 1b 17 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Hospital						2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Virginia b. COUNTY ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Herndon d. STREET ADDRESS 506 Elden St. Route #1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle Robert Last SHEMELD						4. DATE OF DEATH Month APRIL Day 7 Year 19 62							
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-26-08		9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marine Officer				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John L. SHEMELD						14. MOTHER'S MAIDEN NAME Louise JACOBS							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes				16. SOCIAL SECURITY NO.		17. INFORMANT WIFE: KATHERINE SHEMELD, Same as # 2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <input checked="" type="checkbox"/> Basilar artery thrombosis. DUE TO 260 X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Arteriosclerosis (c) diabetes mellitus. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)												INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 22 , 19 62 to April 7 , 19 62 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 7 , 19 72 , and that death occurred at 1140 AM from the causes and on the date stated above.													
22a. SIGNATURE John R. Warmolts MD. M.D.						ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/> April 7, 19 62			
22c. PHYSICIAN'S NAME (Type) JOHN R. WARMOLTS LT MC USN						22d. ADDRESS U. S. Naval Hospital, Bethesda, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-10-62		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON		23d. LOCATION (City, town or county) ARLINGTON, VIRGINIA (State)							
24. FUNERAL DIRECTOR'S SIGNATURE J. Beckley Green ADDRESS GREEN FUNERAL HOME, HERNDON, VIRGINIA						25a. REC'D BY REGISTRAR APR 12 '62		25b. REGISTRAR'S SIGNATURE Arthur L. House					

Einigen

4580 VI

505 Fifth St. N. Suite 100

Robert J.

30-65-e

Washington, D. C.

1997

504 Y. Aizawa et al.

U. S. Naval Supply Depot, Bethesda.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04830
CERTIFICATE OF DEATH
04829

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY in 1b <u>1 week</u>		d. STREET ADDRESS <u>13845 Travillah Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frank E. SIMMONS</u>		4. DATE OF DEATH <u>April 22 19 62</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/18/79</u>	
9. AGE (In years, last birthday) <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>George A. Simmons</u>	
14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Simmons</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Margaret M. Osgood-daughter-same 2d</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Intestinal Obstruction</u> 199X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Carcinomatosis (Generalized)</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		ONSET AND DEATH <u>6 days</u> ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 21 1962</u> to <u>April 22 1962</u> that (I) (we) last saw the deceased alive on <u>April 21 1962</u> , and that death occurred at <u>1:20 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Howard H. Strine</u> M.D.		22b. DATE SIGNED <u>4-22-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard H. Strine</u>		22d. ADDRESS <u>4830 V. St. N.W. Wash. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/24/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Darnestown, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>APR 26 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>William J. Thomas</u>			

04389

04389

(1)

(1)

(Faint handwritten text, possibly a signature or name)

4-11-65

Robert A. Johnson, Bethesda, Maryland
Department of Defense, Washington, D.C.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04831 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04830

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash Stn + Hosp</u>		d. STREET ADDRESS <u>R.F.D. 2 - 1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ruth Ann Slaughter</u>		4. DATE OF DEATH Month Day Year <u>4 17 1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-12-92</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Wash D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>William Stewart</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Baker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Stephen H. Slaughter</u>		Address <u>Husband</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thoracic hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Crushed chest</u> DUE TO (c) <u>Auto accident</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was passenger in car which was struck by other car</u>	
20c. TIME OF INJURY Month, Day, Year <u>4-17 1962</u> Hour min. <u>4:35 p.m.</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. (City or town) (County) (State) <u>Silver Spring Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/21/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Good Hope..</u>		22d. LOCATION (City, town, or country) (State) <u>Colesville, Md.</u>	
23. FUNERAL DIRECTOR <u>Robert R. Sowden</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 25 '62</u>		24b. REGISTRAR'S SIGNATURE <u>William L. Harris</u>	

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04833

04832

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>MD.</u> b. COUNTY <u>MONT.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Iakoma Park</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San + Hospital</u>				c. CITY, OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>16 SILVER SPRING</u>			
3. NAME OF DECEASED (Type or print) <u>Harry P. Smithers</u>				d. STREET ADDRESS <u>1850 A. NORTHAMPTON DR</u>			
5. SEX <u>M</u>				4. DATE OF DEATH Month <u>4</u> Day <u>8</u> Year <u>1962</u>			
6. COLOR OR RACE <u>W</u>				8. DATE OF BIRTH <u>11-21-1892</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. AGE (In years last birthday) <u>69</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>			
10b. KIND OF BUSINESS OR INDUSTRY <u>A. Jenkins</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Thomas Jefferson Smithers</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Huxter</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>127-09-3167</u>			
17. INFORMANT <u>Mrs Valmer Perfuter</u>				Address <u>730 Northampton Dr. Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Arteriosclerotic Heart Disease - Myocardial Ischemia</u> (c) <u>Ischemia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>2 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
2Dc. TIME OF INJURY Hour a.m. <u>19</u> p.m.				2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				2Df. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 1961</u> to <u>Apr. 8, 1962</u> , that (I) <u>was</u> last saw the deceased alive on <u>Apr. 6, 1962</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.				22a. SIGNATURE <u>James L. Laubach</u> M.D.			
22c. PHYSICIAN'S NAME (Type) <u>JAMES L. LAUBACH</u>				22b. DATE SIGNED <u>4/8/62</u>			
22d. ADDRESS <u>1806 Fox Rd - Hyattsville, Md.</u>				22e. REC'D BY REGISTRAR <u>W. T. Attwell</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>APR. 10, 1962</u>			
23c. NAME OF CEMETERY OR CREMATORIUM <u>OAK WOOD</u>				23d. LOCATION (City, town or county) (State) <u>RICHMOND, VA.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. T. Attwell</u>				25b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be furnished by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

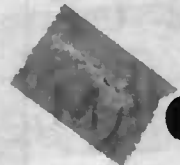
VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04833

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 3 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Pennsylvania b. COUNTY Nanty-Glo c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route #1, Box 133A d. STREET ADDRESS 75X-3	
3. NAME OF DECEASED (Type or print) Donald Richard Snedden		4. DATE OF DEATH April 12 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1927
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Body Repairman		10b. KIND OF BUSINESS OR INDUSTRY Garage	9. AGE (In years last birthday) 34 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Snedden		14. MOTHER'S MAIDEN NAME Byrd Lambing	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) Yes 1945 - 1947		16. SOCIAL SECURITY NO. 282-22-8697	
17. INFORMANT The Medical Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: Cardiovascular Collapse 204.5 DUE TO Staphylococcal Septicemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Acute Renal Failure Urate Nephropathy DUE TO Acute Lymphatic Leukemia	
19. INTERVAL BETWEEN ONSET AND DEATH 16 Hours 16 Hours 16 Hours 3 Weeks		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 9 19 62 to April 12 19 62 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 12 19 62 , and that death occurred at 8:05 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Robert H. Levin M.D.		22b. DATE SIGNED 4/13/62	
22c. PHYSICIAN'S NAME (Type) ROBERT H. LEVIN, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 4-13-62	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY E. N. B. Cemetery	23d. LOCATION (City, town or county) (State) Cambria County, Penna.
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR APR 19 '62	
ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

04833

04833



January 1937

2 days

The Clinical Center, Bethesda, Md.

Richard B. Stetson

June 10, 1937

George B. Stetson

First Landing

William Stetson

The Clinical Center, Bethesda, Md.

Cardiovascular collapse

Statistical analysis

acute renal failure

acute pyelitis

April 9, 1937

April 12

1937

Robert A. Stetson

the Clinical Center, Bethesda, Md.

Robert A. Stetson

Robert A. Stetson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MONTGOMERY STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
04835														
Item 9 Film G311 4/12/62 mh														
04834														
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 2 mo. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) LeDeau Gardens Barker St.					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 3416 - B St. S.E. d. STREET ADDRESS 47X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last Viola Caroline SPENCER					4. DATE OF DEATH Month Day Year APRIL 3 1962									
5. SEX F		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 16 1884		9. AGE (in years last birthday) 77 7/8						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) New Brunswick Canada			12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Benjamin Applebee					14. MOTHER'S MAIDEN NAME Frances Seeley									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. Mrs. Anne Spencer					17. INFORMANT Poolesville, Md. Rt. 1				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA. 4 4-2X DUE TO CONDITONS, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) PYELO NEPHRITIS, CHRONIC DUE TO (c) NEPHROSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSIVE CARDIOVASCULAR DISEASE 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from MAR. 28, 1962 to APR. 3, 1962 that (I) (we) last saw the deceased alive on APR. 3, 1962 and that death occurred at 9:28 , from the causes and on the date stated above.														
22a. SIGNATURE Robert T. Thibadeau M.D.					22b. DATE SIGNED APR. 3-62									
22c. PHYSICIAN'S NAME (Type) ROBERT T. THIBADEAU					22d. ADDRESS 10609 CONCORD ST. KENSINGTON MD									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/6/62		23c. NAME OF CEMETERY OR CREMATORY Monocacy			23d. LOCATION (City, town or county) (State) Beallsville Md.							
24. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton					25a. REC'D BY REGISTRAR APR 9 '62					25b. REGISTRAR'S SIGNATURE Arthur S. Hume				

04233

(M)

Montgomery

Stiver, Irving

Lebanon Gardens

Vieno

Caroline

Nov. 10 1884 178

Housewife

Benjamin Appleby

Frances Bailey

Mr. John Baker, Louisville, Mo. 1884

Benjamin

Monroe

1884

Benjamin

Benjamin, Mo.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

YR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04836

CERTIFICATE OF DEATH

04835

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 23 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE West Virginia b. COUNTY Point Pleasant c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route #1, Box 113 d. STREET ADDRESS 85X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Leslie Charles Sperow		4. DATE OF DEATH Month April Day 22 Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1953
9. AGE (In years last birthday) 8 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles B. Sperow, Jr.		14. MOTHER'S MAIDEN NAME Sylvia Y. Gehri	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary hemorrhage 204 } DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Thrombocytopenia (c) Acute Lymphocytic Leukemia	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH 24 hours 1 month 18 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 30, 1962 to April 22, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 22, 1962 and that death occurred at 8:15AM from the causes and on the date stated above.			
22a. SIGNATURE Robert H. Levin M.D.		22b. DATE SIGNED April 23, 1962	
22c. PHYSICIAN'S NAME (Type) Robert H. Levin, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/25/62	23c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery	23d. LOCATION (City, town or county) (State) Shepherdstown, W. Va.
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR APR 26 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Thane			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Iakoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro - 14x2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hosp.</u>		d. STREET ADDRESS <u>R F D -</u>	
3. NAME OF DECEASED (Type or print) <u>Russell Albert Stewart</u>		4. DATE OF DEATH Month <u>4</u> Day <u>23</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-31-35</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Works</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mr Percy Stewart</u>		14. MOTHER'S MAIDEN NAME <u>Mary Savoy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, not or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC AND RESPIRATORY FAILURE</u> DUE TO <u>914-S</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, } (b) <u>ELECTROCUTION</u> (c) <u>SUDDEN</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Repeated leaning against crane which contacted high tension wires</u>	
20c. TIME OF INJURY Hour <u>3:00</u> p.m. Month, Day, Year <u>4-23 1962</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> et work et work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>		20f. (City or town) <u>Adelphia</u> (County) <u>P. G.</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-27-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Simons Church</u>		22d. LOCATION (City, town, or country) <u>Croom</u> (State) <u>md</u>	
23. FUNERAL DIRECTOR <u>Rollins, Myrtle K.</u>		24a. REC'D BY REGISTRAR <u>APR 30 '62</u>	
ADDRESS <u>4339 Hunt Pl. N.E. Wash. D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thrash</u>	

MEMORANDUM
TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[The following text is extremely faint and largely illegible, appearing to be a memorandum or report. It contains several lines of text, some of which may be names or titles, but they cannot be accurately transcribed.]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the funeral director, by the funeral director, or by the attending physician and completely filled out. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04838

CERTIFICATE OF DEATH

04837

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. LENGTH OF STAY IN 1b 10 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10008 CRESTWOOD ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGARET Middle BORYER Last STONER		4. DATE OF DEATH Month APRIL Day 6 Year 19 62	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 31 1925
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BACTERIOLOGIST		10b. KIND OF BUSINESS OR INDUSTRY US GOVT	
11. BIRTHPLACE (State or foreign country) WASHINGTON MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS C GEARY		14. MOTHER'S MAIDEN NAME ANNA BORYER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT DANIEL DOUB STONER KENSINGTON MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA (SUPRAVENTRICULAR TACHYCARDIA) DUE TO 543X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ACUTE GASTRITIS DUE TO 2 DAYS (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PARAPLEGIA DUE TO BULBOSPINAL POLIOMYELITIS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/6/62 , 19, to 4-7-62 , 19, that I last saw the deceased alive on 4/6/62 , 19, and that death occurred at 11:25 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry C. Scruggs		ADDRESS (Street, city or town, state) 7720 WISCONSIN AVE	
DATE SIGNED 4/8/62			
PHYSICIAN'S NAME (Type) HENRY C SCRUGGS M. D.		BETHESDA MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-10-62	
22c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE SUPER-ROUZER FUNERAL HOME HAGERSTOWN MARYLAND		24a. REC'D BY REGISTRAR DATE APR 10 '62	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

UNITED STATES OF AMERICA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>18 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>3703 Elby St.</u>	
3. NAME OF DECEASED (Type or print) <u>Bessie</u> First <u>-</u> Middle <u>-</u> Last <u>Strauss</u>		4. DATE OF DEATH <u>April 25</u> 19 <u>62</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/10/81</u>
9. AGE (In years, if under 1 year, give months and days) <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Conn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Schyman</u>		14. MOTHER'S MAIDEN NAME <u>Jenny</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Lorraine Smith, daughter same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock - poss. coronary + cerebral infarct</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>diabetes - generalized arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>intra-abdominal mass</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 7, 1962</u> to <u>4-25</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>April 25</u> , 19 <u>62</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John J. Merendino</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>John J. Merendino</u>		22d. ADDRESS <u>11601 Newport Mill Rd. SS, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Apr 30, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arl. Nat'l. Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Arl., Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Hume</u>		25a. REC'D BY REGISTRAR DATE <u>APR 30 '62</u>	
ADDRESS <u>4217 9th St., N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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CERTIFICATE OF DEATH

04839

Item 23b Film 3311 4/26/62 mh

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN TB 1 Month d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Chevy Chase d. STREET ADDRESS 4017 Oliver Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HAZEL RALSTON STRUBLE First Middle Last				4. DATE OF DEATH APRIL 19, 1962 Month Day Year			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 22, 1892 yrs. Months Days Hours Min.	
9. AGE (In years last birthday) 69				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Oregon	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Lonner Owen RALSTON			
14. MOTHER'S MAIDEN NAME Ada K. JOHNS				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. 108-5840				17. INFORMANT Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) hepatic failure 5840 DUE TO chronic hepatitis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 19, 1962 to April 19, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 19, 1962 , and that death occurred at 3:45 AM from the causes and on the date stated above.							
22a. SIGNATURE Paul G. Lineweaver M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) PAUL G. LINEWEAVER LCDR MC USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 23, 1962		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey				25a. REC'D BY REGISTRAR APR 23 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Haines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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U. S. Naval Hospital

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Hospital Report

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FOR STATE HEALTH DEPT. (M)
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md</u> b. COUNTY <u>montg</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville</u>				c. LENGTH OF STAY IN 1b <u>life</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Poolesville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>md. R-109 Poolesville</u>				d. STREET ADDRESS <u>md-R-109</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Moran Benj Summerville</u>				4. DATE OF DEATH <u>Apr 10 1962</u>							
5. SEX <u>male</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-23-96</u>		9. AGE (In years last birthday) <u>65 yrs.</u>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labours</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. &</u>	
13. FATHER'S NAME <u>William Summerville</u>				14. MOTHER'S MARDEN NAME <u>Lethia Plummer</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give year or dates of service)				17. INFORMANT <u>Walter Summerville - Poolesville md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>Apr 10 - 1962</u> Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4-15-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Poolesville, Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Poolesville, Md</u>			
23. FUNERAL DIRECTOR <u>R. L. Snowden</u> ADDRESS <u>Rockville Md</u>				24a. REC'D BY REGISTRAR DATE <u>APR 23 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>					

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MEDICAL DEPARTMENT OF THE ARMY

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1. Name of Patient: [illegible]
2. Age: [illegible]
3. Sex: [illegible]
4. Date of Admission: [illegible]
5. Referring Physician: [illegible]
6. History of Present Illness: [illegible]
7. Physical Examination: [illegible]
8. Laboratory Studies: [illegible]
9. Diagnosis: [illegible]
10. Treatment: [illegible]
11. Prognosis: [illegible]
12. Discharge Instructions: [illegible]
13. Signature of Physician: [illegible]
14. Date of Discharge: [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04842

04841

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE 15,</u> d. STREET ADDRESS <u>104 Hesketh Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EDWIN</u>		4. DATE OF DEATH <u>APRIL 30 19 62</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/1/85</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lawyer</u>	9. AGE (In years last birthday) <u>76</u> yrs. 11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Morgan Swingle</u>		14. MOTHER'S MAIDEN NAME <u>Sarah E. Hodgkins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-54-0835</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 CONGESTIVE HEART FAILURE</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>CORONARY OCCLUSION</u> (c) <u>ARTERIO SCLEROTIC HEART DISEASE</u>		17. INFORMANT <u>Son A. Swingle</u> Address <u>Same as above.</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>2 days</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>EMPHYSEMA</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/24/62</u> to <u>4/30/62</u> , that (I) (we) last saw the deceased alive on <u>4/30/62</u> , and that death occurred at <u>4:35</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles J Savarese Jr.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>4-30-62</u>
22c. PHYSICIAN'S NAME (Type) <u>Charles J Savarese Jr.</u>		22d. ADDRESS <u>4890 Battery Lane, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/4/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Prince George Co. Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>DATE MAY 4 '62</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

(M)

(1)

Sarah E. Hodgkins

577-54-0835

EMILY

4300 Battery Lane, Bethesda, Md.

Robert A. Emdin, Bethesda, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card, page 4 may be retained by the hospital or attending physician. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04843 CERTIFICATE OF DEATH 04842

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring		a. STATE Maryland		b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b 3 years		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8228 New Hampshire Avenue		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Silver Spring		d. STREET ADDRESS 8228 New Hampshire Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First Birdie Middle Virginia Last Taylor				Month April Day 29 Year 1962			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 23, 1885	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Stafford, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Payne				14. MOTHER'S MAIDEN NAME Susie Winkler			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Fannie Beagle 544 Univ. Blvd., E., S.S., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 33 IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Hypertensive Arteriosclerotic Vascular Disease (c) Disease				INTERVAL BETWEEN ONSET AND DEATH Immediate			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from Jan 1959 to April 1962, that (I) (we) last saw the deceased alive on April 25, 1962, and that death occurred at 11:00 PM, from the causes and on the date stated above.							
22a. SIGNATURE Bernard A. Fitzgerald				22b. DATE SIGNED 4-30-62		22c. PHYSICIAN'S NAME (Type) Bernard Fitzgerald	
22d. ADDRESS 217 University Blvd., E. Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-2-62		23c. NAME OF CEMETERY OR CREMATORY Andrews Chapel Cemetery		23d. LOCATION (City, town or county) (State) Stafford Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc. Silver Spring, Maryland				25a. REC'D BY REGISTRAR MAY 2 '62		25b. REGISTRAR'S SIGNATURE Charles S. Fiance	

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Handwritten text, possibly a signature or name, appearing upside down.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 3 Film G312 5/1/62 mb											
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Montg</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>				c. LENGTH OF STAY IN 1b <i>3 yrs</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>26 Silver Spring</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>8101 Eastern Ave - Apt 514</i>				d. STREET ADDRESS <i>8101 Eastern Ave - Apt 514</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>First Middle Last</i> <i>Esther Ruth Tepper</i>				4. DATE OF DEATH <i>Month Day Year</i> <i>Apr 25 1962</i>							
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-5-1914</i>		9. AGE (In years last birthday) <i>47 yrs.</i>		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>				11. BIRTHPLACE (State or foreign country) <i>NEBRASKA</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				13. FATHER'S NAME <i>Carm Jacobson</i>				14. MOTHER'S MAIDEN NAME <i>LENA BATES</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>				16. SOCIAL SECURITY NO. <i>599-36-9136</i>				17. INFORMANT <i>Julian Tepper (son)</i> Address <i>Stein 2</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure</i> 501X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Pneumonia</i> (c) <i>Impacted mucous in Bronchial Tree</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Found dead in bed</i>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Frank J. Brosch</i>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <i>Apr 25-62</i>			
EXAMINER'S NAME (Type) <i>FRANK J. Brosch</i>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>				22b. DATE THEREOF <i>4/27/62</i>				22c. NAME OF CEMETERY OR CREMATORY <i>NATL. MEM. PARK</i>			
22d. LOCATION (City, town, or country) <i>FALLS CHURCH, VA.</i>				22e. ADDRESS <i>Breeding General Home 4217-9th Ave</i>				24a. REC'D BY REGISTRAR <i>APR 27 '62</i>			
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanks</i>											

0113

WORLD WAR II - 1941-1945

1941

1941

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be completed by the hospital or attending physician, and completely filled in by the funeral director. Page 2 may be completed by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Wheaton, Md c. LENGTH OF STAY IN 1b 2 WEEKS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wheaton Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 SILVER SPRING d. STREET ADDRESS 115 SOUTHWOOD AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANCES		4. DATE OF DEATH Month 4 Day 26 Year 1962	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-24-1874
9. AGE (In years last birthday) 87		10. IF UNDER 1 YEAR Months 8 Days 7	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. KIND OF BUSINESS OR INDUSTRY England	
13. FATHER'S NAME ROBERT SUTCLIFFE		14. MOTHER'S MAIDEN NAME ZILLAH GREENWOOD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 1969 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Generalized metastases from Sarcoma of joint. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/52 to 4/26 , 19 62 , that (I) (we) last saw the deceased alive on 4/17 , 19 62 , and that death occurred at 5:45 AM, from the causes and on the date stated above.			
22a. SIGNATURE Aldo Vacca M.D.		22b. DATE SIGNED 4-26-62	
22c. PHYSICIAN'S NAME (Type) Aldo VACCA		22d. ADDRESS 1429 University Blvd, W. Silver Spr, Md	
23a. BURIAL, CREMATION, or other disposal (Specify) Cremation April 27, 1962		23b. DATE THEREOF April 27, 1962	
23c. NAME OF CEMETERY OR CREMATORY Lee Crematory Wash. D.C.		23d. LOCATION (City, town or county) (State) Wash. D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE LEE Funeral Home Wash.		25a. RECD BY REGISTRAR DATE APR 30 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Hanna		25c. ADDRESS	

(1881)

STATE OF NEW YORK

1881

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FOR STATE
HEALTH DEPT.

TO DEDUCT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04846

04845

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Arlington Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>			
c. LENGTH OF STAY in 1b				d. STREET ADDRESS <u>1021 South Barton St.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Resthaven Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Thomas Trussell</u>				4. DATE OF DEATH <u>Apr 30 1962</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 30, 1906</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>30</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Martinsburg, W. Virginia, U. S.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			
13. FATHER'S NAME <u>Millard Trussell</u>				14. MOTHER'S MAIDEN NAME <u>Loraine W. Trussell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
17. REFORMANT Address <u>as no 2</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u> DUE TO <u>029X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Syphilis, Constitutional</u> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Smoking</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> e.m. <u>0</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brosehart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosehart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>5-8-62</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Dale</u>				22d. LOCATION (City, town, or country) (State) <u>Martinsburg-W. Va</u>			
23. FUNERAL DIRECTOR <u>Emmett C. Gartner, Gaithersburg, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE MAY 3 '62</u>			
				24b. REGISTRAR'S SIGNATURE <u>Charles S. Kinner</u>			



James C. [illegible]
[illegible]
[illegible]

Mountain View

March 15, 1915

Dear Sir,

I have the pleasure to acknowledge the receipt of your letter of the 10th inst.

in relation to the matter of the [illegible] [illegible] [illegible]

and in reply to inform you that the same has been forwarded to the proper authorities.

Very respectfully,
[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
04846									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 184 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Washington b. COUNTY 84X-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olympia d. STREET ADDRESS 4703 Opal Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Minnie (No middle name) Unglaub					4. DATE OF DEATH April 13, 1962				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 20 November 1934		9. AGE (In years last birthday) 27 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Michigan			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Robert W. Jeffrey					14. MOTHER'S MAIDEN NAME Nina Stewart				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 386-32-4522		17. INFORMANT The Medical Record, The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 173X IMMEDIATE CAUSE (a) Metastatic Choriocarcinoma DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 2 years									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) OLYMPIA WASH.		20g. (County) WASHINGTON	
21. I certify that (M) (this hospital) attended the deceased from Oct. 11, 1961 to April 13, 1962 , that (H) (we) last saw the deceased alive on April 13, 1962 , and that death occurred at 7:30 AM , from the causes and on the date stated above.									
22a. SIGNATURE Stanley G. Korenman M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED April 13, 1962		
22c. PHYSICIAN'S NAME (Type) Stanley G. Korenman					22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 4/18/62		23c. NAME OF CEMETERY OR CREMATORY 1400 Chapin St NW Washington DC			23d. LOCATION (City, town or county) (State) OLYMPIA WASH.		
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co.					25a. REC'D BY REGISTRAR APR 17 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hines		

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John J. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be read by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
04848					04847				
Item 23b, Film 0312 5/3/62 iwk									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>35 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>					d. STREET ADDRESS <u>1104 Parrish Drive</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Alice</u> Last <u>Van Pelt</u>					4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>19 62</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10 December 1913</u>		9. AGE (In years last birthday) yrs. <u>48</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail</u>		11. BIRTHPLACE (State or foreign country) <u>Minnesota</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Jule Pagnac</u>					14. MOTHER'S MAIDEN NAME <u>Georgia Elfrink</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>502-10-4583</u>		17. INFORMANT <u>The Medical Record, Address</u> <u>The Clinical Center, Bethesda 14, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> <u>204.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>Acute Myelogenous Leukemia</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>10 months</u>									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>March 20, 1962</u> to <u>April 24, 1962</u> , that (I) (we) last saw the deceased alive on <u>April 24, 1962</u> , and that death occurred at <u>10:35</u> A. M. from the causes and on the date stated above.									
22a. SIGNATURE <u>Robert H. Levin</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <u>April 24, 1962</u>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>Robert H. Levin, M.D.</u>					22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit/1/1/26/62</u>			23b. DATE THEREOF <u>4/30/62</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Warren, Minn.</u>			23d. LOCATION (City, town, or county) _____ (State) _____
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lyson Wheeler Funeral Home</u>					13. ADDRESS <u>1311 West Montg. Ave. Rockville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 27 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04849

CERTIFICATE OF DEATH

04848

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in lb <u>12 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> <u>1656-2</u> d. STREET ADDRESS <u>1412 Kanawha Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Maxine Wright Veirs</u>				4. DATE OF DEATH <u>April 13, 1962</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/27/13</u>					
9. AGE (In years last birthday) <u>48</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Texas</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months Days	Hours Min.										
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Elmo L. Wright</u>							
14. MOTHER'S MAIDEN NAME <u>Gladys Mattes</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>							
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Mother, Gladys Wright, 2039 New Hampshire Ave., Washington, D. C.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive bleeding from esophageal varices</u> DUE TO <u>Hepatic failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Carbosis of Liver</u> DUE TO <u>4 days</u> DUE TO <u>1 year +</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>4-31</u> , 19 <u>62</u> to <u>4-13</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>4-12</u> , 19 <u>62</u> , and that death occurred at <u>2</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>J. W. Peabody, Jr.</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-13-62</u>					
22c. PHYSICIAN'S NAME (Type) <u>J. W. Peabody, Jr., M.D.</u>				22d. ADDRESS <u>1150 Conn. Ave N.W. Wash. DC</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>4/17/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> <u>Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>APR 18 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MONTGOMERY STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04850

04849

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dawsonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Matthews Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Chevy Chase</u> d. STREET ADDRESS <u>4923 Chevy Chase Blvd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Louise Reach Wade</u>			4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1962</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 13, 1870</u>		9. AGE (In years last birthday) <u>91</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>W. C. Murphy III-grandson-same 2d</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic-Cardiovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (e), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>years</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u>19</u> e.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>30 Jan 1961</u> to <u>25 Apr 1962</u> , that (I) (we) last saw the deceased alive on <u>24 Apr 1962</u> and that death occurred at <u>5:15 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Gordon M. Smith</u>			22b. DATE SIGNED <u>25 Apr 62</u>		22c. PHYSICIAN'S NAME (Type) <u>Gordon M. Smith, MD</u>		
22d. ADDRESS <u>Barnesville, Md.</u>			22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>4/25/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town or county) <u>Suitland, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>			25a. RECORDING OFFICE <u>APR 30 1962</u>				
25b. RECORDING OFFICE <u>APR 30 1962</u>			25c. RECORDING OFFICE <u>Arthur L. Kline</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

VR AIS (4)
 15M 7/61

04500

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04851
CERTIFICATE OF DEATH
04850

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (rural) c. LENGTH OF STAY IN 1b 20 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Hospital, Bethesda, Md.				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE D.C. b. COUNTY D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C. d. STREET ADDRESS 719 "G" St. S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Emmett Doyle WALLER				4. DATE OF DEATH Month Day Year April 13 1962											
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-5-84		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days 77		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Navy				10b. KIND OF BUSINESS OR INDUSTRY Retired				11. BIRTHPLACE (County & State, or foreign country) Kansas				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Emett Waller						14. MOTHER'S MAIDEN NAME Elizabeth Doyle									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 1907-1938				16. SOCIAL SECURITY NO. 578 26 7059				17. INFORMANT Wife: Mrs. Beaulah M. Waller, Same as #2				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Purulent meningitis 340.3 DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 24, 1962 , to April 13, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 13, 1962 , and that death occurred at 4:05 AM on the causes and on the date stated above.															
22a. SIGNATURE D. L. Kelly				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.				22b. DATE SIGNED 13 April 1962							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 17 APRIL 62		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL				23d. LOCATION (City, town or county) (State) ARLINGTON, Va.							
24. FUNERAL DIRECTOR'S SIGNATURE R.A. MATTINGLY				ADDRESS 131 11th ST., S.E. WASHINGTON, D.C.				25a. REC'D BY REGISTRAR APR 16 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Hearn					

TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician. Page 2 may be filed by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04852
04851

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY in 1b 74 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 50 Chevy Chase d. STREET ADDRESS 1 3911 Parsons Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bertha B. Walter		4. DATE OF DEATH April 4, 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 16, 1882
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 4 Days 18	11. IF UNDER 24 HRS. Hours 4 Min. 18
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James M. Baer	
14. MOTHER'S MAIDEN NAME Hannah A. Leiby		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. James H. LeVan, daughter same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Infarction, Left 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Arteriosclerotic C.V. Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 7 days yrs		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1962 to APR 4 , 1962, that (I) (we) last saw the deceased alive on APR 4 , 1962, and that death occurred at 8:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE DeWitt E. DeLawter M.D.		22b. DATE SIGNED 4-4-62	
22c. PHYSICIAN'S NAME (Type) DEWITT E. DELAWTER		22d. ADDRESS 8025 ABERDEEN RD Bethesda Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 4-6-62		23b. DATE THEREOF 4-6-62	
23c. NAME OF CEMETERY OR CREMATORY Charles Evans Cemetery		23d. LOCATION (City, town or county) (State) Reading, Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR APR 6 '62	
ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Evans	

1880

1880



Nov. 10, 1882

Female White

Housewife

None

No

Charles, Anna Cemetery, Bannock, Idaho.

Robert A. Pumphrey

Bethesda, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **MARYLAND STATE DEPARTMENT OF HEALTH**
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04853		04852	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4525 Sleaford Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>10506 Weymouth St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Victor</u> <u>Winfield</u> <u>Wanser</u>		4. DATE OF DEATH <u>April</u> <u>10</u> <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 12, 1896</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone installer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone</u>	
11. BIRTHPLACE (Country & State, or foreign country) <u>Brooklyn N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Wanser</u>		14. MOTHER'S MAIDEN NAME <u>Harriet De no</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>W.W.I</u>		16. SOCIAL SECURITY NO. <u>061-10-2646</u>	
17. INFORMANT <u>wife -</u>		Address <u>same</u> <u>Gertrude</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Atherosclerosis</u> DUE TO <u>Atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>seconds</u> <u>seconds</u> <u>15 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> e.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from <u>Feb 14</u> <u>1962</u> to <u>March 31</u> <u>1962</u> ; that (I) (we) last saw the deceased alive on <u>March 31</u> <u>1962</u> and that death occurred at <u>11:45 AM</u> from the causes and on the date stated above.		22b. DATE SIGNED <u>April 10, 1962</u>	
22a. SIGNATURE <u>Allen J. O'Neill</u> M.D.		22c. PHYSICIAN'S NAME (Type) <u>Allen J. O'Neill</u>	
22d. ADDRESS <u>8601 Old Georgetown Rd, Bethesda Md.</u>		22e. REC'D BY REGISTRAR <u>APR 13 '62</u>	
22f. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		22g. REGISTRAR'S SIGNATURE	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit 4/11/62</u>		23b. DATE THEREOF <u>4/11/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City, town or county) (State) <u>New York, New York</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		25. REC'D BY REGISTRAR <u>APR 13 '62</u>	

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TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>12</u> <u>da</u> <u>s</u>		d. STREET ADDRESS <u>4525 North Chelsea Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>C.</u> Last <u>Wells</u>		4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/2/80</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Morris Mangan</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Wren</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Catherine Barry, daughter, 7904 Wildwood Dr.</u>		Address <u>Takoma Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Advanced Age</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 HRS</u> <u>10 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1952</u> to <u>April 1962</u> , that (I) (we) last saw the deceased alive on <u>4/25</u> 19 <u>62</u> and that death occurred at <u>11:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert A. Pumphrey</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT A. PUMPHREY M.D.</u> <u>8212 WISSE AVE</u>		22b. DATE SIGNED <u>4/26/62</u>	
22d. ADDRESS <u>BETHESDA 14 MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/28/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Prince George Co. Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		ADDRESS <u> </u>	
25a. REC'D BY REGISTRAR <u>APR 30 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

(M)

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Robert A. Pumphrey, Bethesda, Maryland
Bureau of the Census, Washington, D.C.
4/26/52

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FOR STATE
HEALTH DEPT.
M
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
04855											
04854											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 9 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital					2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE Maryland b. COUNTY Frederick ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick 1035-2 d. STREET ADDRESS 15 S. Virginia Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Daniel Ellsworth WENNER					4. DATE OF DEATH Month April 23, Day 19 62						
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 22 June 1931		9. AGE (In years last birthday) 30 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
13. FATHER'S NAME Charles Lee Wenner					14. MOTHER'S MAIDEN NAME Unk						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 7/51 - 4/62					16. SOCIAL SECURITY NO. 228-42-3834					17. INFORMANT Address Mrs. Charles L. Wenner Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ante-dural hemorrhage with necrosis 900-6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Fracture of skull DUE TO (c) fall down stairs INTERVAL BETWEEN ONSET AND DEATH 9 days											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Reported fall down stairs at Con. Legion dance						
20c. TIME OF INJURY Month, Day, Year Hour e.m. 12:10 p.m. 4-15-1962					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> Building						
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Frederick Frederick Md					20f. (City or town) (County) (State)						
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Frank J. Broschart					CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) FRANK J. Broschart					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 4-27-62						
22c. NAME OF CEMETERY OR CREMATORY New Jerusalem Lutheran Church Cemetery					22d. LOCATION (City, town, or country) (State) Lovettsville, Virginia						
23. FUNERAL DIRECTOR C. H. Feete & Brother, Brunswick, Maryland					24a. REC'D BY REGISTRAR APR 30 '62						
24b. REGISTRAR'S SIGNATURE Arthur L. Evans											

10-21-51

MEDICAL RESEARCH CENTER OF DATA

10-21-51

Virginia

Richmond

15 E. Virginia St.

April 15, 1951

June 1951

Virginia

Rich

Mr. Charles D. Hunter

Richmond (VA)

U. S. Navy

Richmond

U. S. Navy

U. S. Navy

Charles D. Hunter

10-21-51

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10-21-51

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be completed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04856

04855

1. PLACE OF DEATH a. COUNTY Montgomery Co., MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kensington Gardens Sanitarium		d. STREET ADDRESS 1223 'M' St. N. W.	
3. NAME OF DECEASED (Type or print) Edith Wilcox		4. DATE OF DEATH APRIL 30th, 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 6, 1877
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 5 Days 24 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY HOME-MAKER	
11. BIRTHPLACE (County & State, or foreign country) London, England		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ??		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. ??	
17. INFORMANT (FRIEND) WASHINGTON, D. C.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) Cardiac failure	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) Intericardiac Left Atrial Thrombosis 34 yrs		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) fractured left femur - Feb '62	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 1, 1942 to Apr 30, 1962 ; that (I) (we) last saw the deceased alive on 4/27/62 , and that death occurred from from the causes and on the date stated above.			
22a. SIGNATURE E. Aschenbach		22b. DATE SIGNED May 2, 1962	
22c. PHYSICIAN'S NAME (Type) Dr. E. Aschenbach		22d. ADDRESS 1841 Cal Rd NW	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/1/1962	
23c. NAME OF CEMETERY OR CREMATORY 13 Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Southland Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hogson Funeral Home		25a. REC'D BY REGISTRAR WASH. 5, D. C.	
25b. REGISTRAR'S SIGNATURE Arthur S. Evans		25c. DATE MAY 2 '62	

M

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1893

STATE OF NEW YORK

1893

RECEIVED

CO.

WASHINGTON

WASHINGTON, D.C.

ONE MONTH

WASHINGTON

RECEIVED ON OCTOBER 1893

1893

WASHINGTON, D.C.

RECEIVED

WASHINGTON

WASHINGTON, D.C.

Female

White

Jan 6, 1893

Housewife

Housewife

London, England

USA

1893

WASHINGTON, D.C.

WASHINGTON, D.C.

Handwritten notes and signatures, including "The Washington Post" and "The Washington Times".

Oct 1893

1893

Handwritten signature: Dr. H. A. Schenck

1893

1893

Handwritten text at the bottom of the page, possibly a date or reference.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04857

04856

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u> c. LENGTH OF STAY IN lb <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>KENSINGTON GARDENS SAN.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BRUNSWICK</u> <u>1035-2</u> d. STREET ADDRESS <u>—</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>BETTIE E. Williams</u>				4. DATE OF DEATH Month Day Year <u>4 19 1962</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 29 - 1890</u> <u>71</u> yrs.		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Frederick, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Koogle</u>				14. MOTHER'S MAIDEN NAME <u>MARY Beachley</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic melanoma</u> <u>190.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>melanoma (on back)</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>										INTERVAL BETWEEN ONSET AND DEATH <u>28 months</u> <u>28 months</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>July 14</u> , 19 <u>61</u> , to <u>April 19</u> , 19 <u>62</u> , that (I) (<u>was</u>) last saw the deceased alive on <u>April 19</u> , 19 <u>62</u> , and that death occurred at <u>12:38 P</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Aaron H. Trau</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>April 19 1962</u>					
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>8237 Georgia Ave Silver Spring Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>4/20/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN BROTHERHOOD</u>		23d. LOCATION (City, town or county) (State) <u>MIDDLETOWN, MARYLAND</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Teile Funeral Home Brunswick</u>				ADDRESS		25a. REC'D BY REGISTRAR DATE <u>APR 23 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04858

CERTIFICATE OF DEATH

04857

1. PLACE OF DEATH e. COUNTY <i>Montgomery</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Ednor</i> c. LENGTH OF STAY IN 1b <i>1 WEEK</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Belmont nursing home</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) e. STATE <i>MD.</i> b. COUNTY <i>Prince Georges</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>LANHAM</i> d. STREET ADDRESS <i>6409 Princess Garden</i> e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) First <i>Marian</i> Middle <i>Hester</i> Last <i>Williams</i>		4. DATE OF DEATH Month <i>4</i> Day <i>27</i> Year <i>1962</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Feb 5 1877</i>
9. AGE (In years last birthday) <i>85</i> yrs.		IF UNDER 1 YEAR Months <i>4</i> Days <i>27</i>	IF UNDER 24 HRS. Hours <i>19</i> Min. <i>62</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <i>Charles County, Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>Ephraim Williams</i>	
14. MOTHER'S MAIDEN NAME <i>Hester Rawlings</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT Address <i>4545 Conn. Ave Washington D.C.</i> <i>Mrs. James A. McElary</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Peritonitis</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Abdominal Carcinomatosis</i> (c) <i>—</i> DUE TO (e), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>Draining obturator (rt) sinus tract</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <i>4/19</i> 20d. INJURY OCCURRED <i>4/19</i> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>4/19</i> 20f. (City or town) <i>4/27</i> (County) <i>4/27</i> (State) <i>4/27</i>			
21. I certify that (I) (this hospital) attended the deceased from <i>4/19</i> to <i>4/27</i> 1962 that (I) saw the deceased alive on <i>4/26</i> 1962 and that death occurred at <i>4:27 PM</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>John P. Martin MD</i>		22b. DATE SIGNED <i>4/27/62</i>	
22c. PHYSICIAN'S NAME (Type) <i>JOHN P. MARTIN, MD</i>		22d. ADDRESS <i>SANDY SPRING MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/1/62</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Congressional Cem</i>		23d. LOCATION (City, town or county) <i>Washington, D.C.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Halleys Funeral Home, Inc.</i>		25a. REC'D BY REGISTRAR <i>APR 30 '62</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>			

1880

1880

1880

(11)

Handwritten notes, possibly a list or ledger, with various entries and dates. Some legible words include "Lumber", "1880", "1881", "1882", "1883", "1884", "1885", "1886", "1887", "1888", "1889", "1890", "1891", "1892", "1893", "1894", "1895", "1896", "1897", "1898", "1899", "1900".

Handwritten text, possibly a title or heading, located in the middle of the page.

Handwritten notes at the bottom of the page, including dates and possibly names or locations. Some legible words include "1880", "1881", "1882", "1883", "1884", "1885", "1886", "1887", "1888", "1889", "1890", "1891", "1892", "1893", "1894", "1895", "1896", "1897", "1898", "1899", "1900".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04859

04858

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN b. <u>10 MONTHS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>302 DEARBORN AVE</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>223 SILVER SPRING</u> d. STREET ADDRESS <u>302 DEARBORN AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>RHODA</u> First <u>EMMA</u> Middle <u>WITT</u> Last 4. DATE OF DEATH <u>APRIL 6</u> Month <u>6</u> Day <u>19</u> Year <u>1962</u>				5. SEX <u>FEM</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			
8. DATE OF BIRTH <u>22 DEC 1889</u> 9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAMSTRESS</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED (CLOTHING)</u> 11. BIRTHPLACE (County & State, or foreign country) <u>TENN</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>MARION DANIEL WITT</u> 14. MOTHER'S MAIDEN NAME <u>ALICE T. McBEE</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NONE</u> 16. SOCIAL SECURITY NO. <u>41-05-5099</u> 17. INFORMANT <u>MINNIE K. COLLINS</u> Address <u>302 DEARBORN AVE S.S. MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Arteriosclerosis Generalized</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Auricular fibrillation</u> <u>Congestive heart failure</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of form 18.) <u> </u>			
20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u> </u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>30 Nov 1959</u> to <u>6 Apr 1962</u> that (I) (we) last saw the deceased alive on <u>5 Apr 1962</u> and that death occurred at <u>8:45 p</u> from the causes and on the date stated above.						22a. SIGNATURE <u>Thomas P Fogarty</u> 22b. DATE SIGNED <u>6 Apr 62</u>	
22c. PHYSICIAN'S NAME (Type) <u> </u>				22d. ADDRESS <u>1011 UNIV. BLVD. E. Silver Spring MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/7/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WHITE PINE CEMETERY</u>		23d. LOCATION (City, town or county) <u>WHITE PINE</u> (State) <u>TENN</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u> ADDRESS <u> </u>				25a. REC'D BY REGISTRAR <u> </u> DATE <u>APR 11 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

0321

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REDA AMMA UNIT 1994 6 02
20 DEC 1994

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General Information
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General Information

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and that it may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
04859											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Congressional Manor Sanitarium 9200 Rockville Pike						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 57 Springfield d. STREET ADDRESS 1 5613 Lamar Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Elizabeth J. Wood						4. DATE OF DEATH April 2, 1962					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/20/1884		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Auditor-Internal Revenue-				10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas B. Wood						14. MOTHER'S MAIDEN NAME Elizabeth J. Relf					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs. Sarah W. Porter Address 5613 Lamar Road Washington 16, D.C.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO Arteriosclerosis generalized (c) Diabetes mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Diabetes mellitus INTERVAL BETWEEN ONSET AND DEATH 4 days 7 years 7 years											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 8-1-58 to 4-2-62 , that (I) (the) last saw the deceased alive on 3-29-62 and that death occurred at 6 p.m. from the causes and on the date stated above.											
22a. SIGNATURE C. Roger Kurtz, M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-2-62			
22c. PHYSICIAN'S NAME (Type) C. Roger Kurtz, M.D.						22d. ADDRESS 3701 Conover W. Wash. D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4/5/62		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) Prince Georges County, Md. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Harris Co.						25a. REC'D BY REGISTRAR Wash. D.C.		25b. REGISTRAR'S SIGNATURE Arthur E. Harris			
DATE											

1993

422

10-10-1964

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

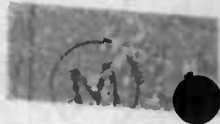
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04861

04860

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ednor c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Belmont Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Chevy Chase d. STREET ADDRESS 4810 Granthan Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Carl Z Work		4. DATE OF DEATH Month April Day 4 Year 19 62	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 3, 1876	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 4 Days 1 IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landscape Gardner		10b. KIND OF BUSINESS OR INDUSTRY Gardner	
11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Work		14. MOTHER'S MAIDEN NAME Laura Crounover	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war and dates of service) Sp. American		16. SOCIAL SECURITY NO. None	
17. INFORMANT Martin H. Work, Son-same above		Address 	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive Heart Failure DUE TO (b) Arteriosclerotic Ht. Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
INTERVAL BETWEEN ONSET AND DEATH 1 month sev'l yrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/18/1962 , 19 61 , to 4/4/1962 , that (I) (we) last saw the deceased alive on 3/28/1962 , and that death occurred at 6:10 AM, from the causes and on the date stated above.			
22a. SIGNATURE Donald Nelson M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Donald Nelson		22d. ADDRESS 10620 Georgia Ave. Silver Spring, Md	
22e. DATE SIGNED 4/4/62			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/6/62	
23c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR APR 6 '62	
		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	



04500

Post Office

Post Office

Post Office

Post Office

Post Office

Belmont National Hotel

4810 Chestnut Avenue

Post Office

Post Office

Post Office

Mail - White

Dec. 1, 1918

Post Office

Lawrence Gardner

Coroner

Illinois

USA

James J. Fox

James J. Fox

James J. Fox, 1111 N. 1st St., St. Louis, Mo.



Robert A. Humphrey, Bethesda, Maryland, June 22
Attestation Cemetery, Arlington, Virginia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician. Page 2 may be filed by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04862

04861

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> f. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> D.C.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash San & Hosp</u>		d. STREET ADDRESS <u>13 Shaw Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Ralph Frank Wurtz</u>		4. DATE OF DEATH <u>Apr 27</u> 19 <u>62</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-11-00</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plate Finisher Bur of Engr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Illinois</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Henry Wurtz</u>		14. MOTHER'S MAIDEN NAME <u>Louise Lechow</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or, unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>MRS. Mildred Wurtz - Same</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO <u>Recurrent myocardial infarctions 6 in 5 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Myocarditis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1930</u> to <u>27 April 1962</u> that (I) (we) last saw the deceased alive on <u>24 April 1962</u> and that death occurred at <u>7:50</u> P.M. from the causes and on the date stated above.		22a. SIGNATURE <u>Thomas E. Mattingly M.D.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>27 Apr 62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas E. Mattingly, M.D.</u>		22d. ADDRESS <u>2200 R.I. Ave N.E. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-30-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond Q. Zick</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Hume</u>	
25b. REGISTRAR'S SIGNATURE		25c. DATE <u>MAY 2 '62</u>	

Warner E. Pumphrey, Inc., Silver Spring, Maryland

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be used by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 30 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Resmor Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE D. C. b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 3339 Nichols Ave. S. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Susie V. Wynn		4. DATE OF DEATH April 11 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10, 1892
9. AGE (In years last birthday) 70 yrs.		10. AGE (In years last birthday) 2 Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hookkeeper		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Samuel Kerby		14. MOTHER'S MAIDEN NAME Marian Watson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Birscoe, Sister-Chevy Chase, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRCULATORY COLLAPSE 420.00 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MYOCARDIAL INFARCTION, ACUTE DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE INTERVAL BETWEEN ONSET AND DEATH 2 HRS 2 HRS 10 YRS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) D.N.A.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/2/62 1962 , to 4/11/62 , that (I) (we) last saw the deceased alive on 4/8/62 , and that death occurred at 10:15 P. , from the causes and on the date stated above.			
22a. SIGNATURE Charles J. Savarese MD.		22b. DATE SIGNED Apr. 12, 1962	
22c. PHYSICIAN'S NAME (Type) CHARLES J. SAVARESE		22d. ADDRESS 4890 Battery Lane, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit		23b. DATE THEREOF 4/13/62	
23c. NAME OF CEMETERY OR CREMATORY Greenhill Cemetery		23d. LOCATION (City, town or county) (State) Danville, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR APR 17 '62	
		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

1943

STATE OF MARYLAND

1943

Washington

30 days

Bellevue

General Hospital

1330 Nichols Ave. N. E.

April 13

1943

June

Feb. 10, 1943

Female

Washington D. C.

Booked

Marion Garber

Samuel Garber

Notes

CHILD AT RISK

PHYSICAL EXAMINATION

PHYSICAL EXAMINATION

1943

4/13/43

Apr. 13, 1943

1000 Bacteriophage

CHARLES J. SAVARDE

Bureau of Health, State of Maryland, Baltimore, Maryland

Robert A. Buncher, Baltimore, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04864 Item 9 Film G310 4/11/62 1wk & 14
04863

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Sakima Park</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Sakima Park</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>7416 Holly Avenue</i>		d. STREET ADDRESS <i>7416 Holly Avenue</i>	
3. NAME OF DECEASED (Type or print) First <i>GEORGE</i> Middle <i>-</i> Last <i>Yalsic</i>		4. DATE OF DEATH Month <i>4</i> Day <i>3</i> Year <i>1962</i>	
5. SEX <i>m</i>	6. COLOR OR RACE <i>w</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 28, 1895</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bookkeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>same</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Syracuse Pa.</i>
13. FATHER'S NAME <i>Anthony Yalsic</i>		14. MOTHER'S MAIDEN NAME <i>Anna unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>118-07-6363</i>	
17. INFORMANT <i>Ms. Barbara Yalsic (same as #2)</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic Ca</i> 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <i>Carcinoma of Rectum</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i> <i>2 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <i>e.m.</i> Month, Day, Year <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>April 1960</i> to <i>April 3, 1962</i> , that (I) (we) last saw the deceased alive on <i>April 2, 1962</i> , and that death occurred at <i>2 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Irving W. Winik</i>		22b. DATE SIGNED <i>4/3/62</i>	
22c. PHYSICIAN'S NAME (Type) <i>Irving W. Winik</i>		22d. ADDRESS <i>3900 McKinley St. N.W.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	23b. DATE THEREOF <i>April 4, 1962</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Fair Lakes Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>Prince George's Co. Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Walters</i>		25. REC'D BY REGISTRAR <i>Arthur S. Kane</i>	
ADDRESS <i>254 Carroll St NW Wash. DC</i>		25b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04865						04864					
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase d. STREET ADDRESS 9 Magnolia Parkway 53 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) IDA PERRY YOUNG						4. DATE OF DEATH April 22 1962					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-6-1873		9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home				10b. KIND OF BUSINESS OR INDUSTRY - - -				11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Proby Young						14. MOTHER'S MAIDEN NAME Ida Perry					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -				16. SOCIAL SECURITY NO. None		17. INFORMANT Capt. John B. Brown, 7825 Aberdeen Rd. Bethesda, Md. Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Kidney failure & uremia 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Fracture left hip (intercapular) DUE TO (c) Congestive heart failure & general arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Fracture left hip (intercapular) 17 days INTERVAL BETWEEN ONSET AND DEATH 10 days 147 days 25 year											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on stairs							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) Chevy Chase (County) Montgomery (State) Md.			
21. I certify that (I) (this hospital) attended the deceased from April 6, 1962 to April 22, 1962 , that (I) (we) last saw the deceased alive on April 20, 1962 , and that death occurred at 5:10 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Gilbert B. Rude M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED April 23, 62			
22c. PHYSICIAN'S NAME (Type) Gilbert B Rude						22d. ADDRESS 3900 Military rd. N.W DC					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-25-1962		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery				23d. LOCATION (City, town or county) Washington, D. C. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Hawler's Son				ADDRESS 1756 Pa. Ave., Wash. DC				25a. REC'D BY REGISTRAR APR 25 62		25b. REGISTRAR'S SIGNATURE Charles E. ...	

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